APHIA*plus* Northern Arid Lands

Final Report

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LIST OF ABBREVIATIONS

AAC	Area Advisory Committee
AB	Abstinence and/or Being Faithful
AFB	Acid Fast Bacillus
AIDS	Acquired Immune Deficiency Syndrome
AOP	Annual Operational Plan
APHIA	AIDS, Population and Health Integrated Assistance Program
APR	Annual Progress Report
ARIFU	AIDS Response in Forces in Uniform (Project)
ART	Antiretroviral Therapy
ARV	Antiretroviral
BC	Behavior Change
BTL	Bilateral Tubal Ligation
C4M	Care for Mothers
HCT	Counselling and Testing
CACC	Constituency AIDS Control Committee
CBT	Capacity-building Team
CCC	Comprehensive Care Center
CDC	Centers for Disease Control and Prevention
CDF	Constituency Development Fund
CHANIS	Child Health and Nutrition Information System
CHBC	Community and Home-Based Care
CHC	Community Health Committees
CHV	Community Health Volunteer
CIC	Community Implementation Committee
CME	Continuing Medical Education
CORP	Community-Own Resource Person
CTS	Clinical Training Skills
CSI	Child Survival Index
DASCO	District AIDS and STI Control Officer
DCC	District Community Coordinator
DFC	District Facility Coordinator
DHMT	District Health Management Team
DHRIO	District Health Records Information Officer
DHSF	District Health Stakeholders Forum
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
DMS	Director of Medical Services
DMLT	District Medical Laboratory Technologist
DTC	Diagnostic Testing and Counselling
DQA	Data Quality Audit
DRH	Division of Reproductive Health
DVI	Division of Vaccines and Immunization
EID	Early Infant Diagnosis
EHP	Emergency Hiring Plan
EMOC	Emergency Obstetric Care
ESD	Extending Service Delivery
FBO	Faith-based Organization
FPPS	Family Programmes Promotion Services
FHI	Family Health International
FRL	Female Religious Leaders
GOK	Government of Kenya
GPS	Global positioning system
GIS	Geographic Information System
HAART	Highly Active Antiretroviral Therapy

HBC	Home-based Care
HCBC	Home and Community-Based Care
HCSM	Health Commodities and Services Management
HCT	HIV Counselling and Testing
HCV	Health Care Volunteer
HEI	HIV-Exposed Infant
HIV	Human Immunodeficiency Virus
HINI	High-Impact Nutrition Interventions
HMIS	Health Management Information Systems
HR	Human Resources
HRM	Human Resources Management
HRH	Human Resources for Health
HRIO	Health Records and Information Officer
HTSP	Healthy Timing and Spacing of Pregnancies
ICB	Institutional Capacity-building
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
IP	Implementing Partner
IUFD	Intrauterine Foetal Death
IYCF	Infant and Young Child Feeding
KAIS	Kenya AIDS Indicator Survey
KCIU	Kenya Council of Imams and Ulamaa
KEMRI	Kenya Medical Research Institute
KNASP	Kenya National AIDS Strategic Plan
LIP	Local Implementing Partner
LLITN	Long-Lasting Insecticide-Treated Nets
LMS	Leadership, Management and Sustainability
LOC	Locational OVC Committee
LOE	Level of Effort
LOP	Life of Project
M&E	Monitoring and Evaluation
MARP	Most at Risk Population
MDR-TB	Multi-Drug Resistant Tuberculosis
MLS	Management and Leadership Specialist
MOH	Ministry of Health
MOPHS	Ministry of Public Health and Sanitation
MOMS	Ministry of Medical Services
MT	Magnet Theatre
MSH	Management Sciences for Health
MTC	Medical Training College
NACC	National AIDS Control Council
NAL	Northern Arid Lands
NASCOP	National HIV and AIDS and STI Control Program
NCAPD	National Coordinating Agency for Population and Development
NCCS	National Council of Children Services
NEPTRC	North Eastern Province and Tana River County
NEPHIAN	North Eastern Province HIV and AIDS Network
NEWS	North Eastern Welfare Society
NHSSP	National Health Sector Strategic Plan
NHP	Nutrition and HIV Project
NOPE	National Organization of peer educators
NPHLS	National Public Health Laboratories Services
NQMG	National Quality Management Guidance
NRHS	Nyanza Reproductive Health Society
OI	Opportunistic Infection

OJT	On-the-Job Training
OOP	Office of the President
OVC	Orphans and Vulnerable Children
PAC	Post-Abortion Care
PASCO	Provincial AIDS and STD Coordinator
PCR	Polymerase Chain Reaction
PD/Hearth	Positive Deviance/Hearth
PEPFAR	President's Emergency Program for AIDS Relief
PGH	Provincial General Hospital
PHMT	Provincial Health Management Team
PICT	Provider-Initiated Counselling and Testing
PLHIV	People Living with HIV
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PNA	Performance Needs Assessment
PNC	Post-Natal Care
PTC	Post-Test Club
QA	Quality Assurance
RRI	Rapid Results Initiative
SCMS	Supply Chain Management System
SIMAHO	Sisters Maternity Home
SILC	Savings and Internal Lending Communities
SNA	Sexual Networks Assessment
STI	Sexually Transmitted Infections
STTA	Short-Term Technical Assistance
SUPKEM	Supreme Council of Kenyan Muslims
SW	Sex Worker
TA	Technical Assistance
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TIMS	Training Information Management System
TMP	Training Master Plan
TNA	Training Needs Analysis
TR	Tana River
TOF	Training of Facilitators (also refers to a facilitator him/herself)
TOT	Training of Trainers (also refers to a trainer him/herself)
TOWA	Total War Against HIV and AIDS
UES	Upper Eastern/Samburu
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
VSL	Village Savings and Loan
WASDA	Wajir South Development Agency
YCF	Young Child Feeding
YFS	Youth-Friendly Services
YTD	Year to Date

I. PROGRAM DESCRIPTION

APHIA (AIDS, Population and Health Integrated Assistance) II North Eastern Province (NEP) was an agreement between the Government of Kenya and USAID which commenced on May 14, 2007. The Project brought together a team of organizations: Pathfinder International (managing partner); Management Sciences for Health; IntraHealth International; and, Family Program Promotion Services (FPPS; subsequently left the consortium in February 2008 and was not replaced). The Project also worked with numerous local implementing partners, including government ministries, non-governmental, faith-based and community organizations.

APHIA II NEP supported integrated service delivery in the technical areas of HIV and AIDS, malaria, family planning, tuberculosis and MNCH. The Project emphasized service integration at all levels as a build-up to sustainability; all project activities were aligned with GoK policies and strategies. APHIA II NEP featured three result areas:

Result 1 – improved and expanded facility-based HIV/AIDS, TB and RH/FP services
Result II – expanded civil society activities to increase healthy behavior
Result III – expanded care & support for people and families affected by HIV/AIDS

In January 2011, the Project's mandate and geographical coverage was expanded and the Project's name was changed to APHIA*plus* (AIDS, Population, and Health Integrated Assistance; *plus* stands for people-centered; leadership; universal access; and, sustainability) Northern Arid Lands (NAL). Two additional partners joined the team: Food for the Hungry; and, International Rescue Committee.

Activities fell into two result areas:

- increased use of quality health services, products and information; and,
- social determinants of health addressed to improve the well-being of marginalized, poor and underserved populations.

The Project covered the northern 60% of Kenya, an area characterized by remote, nomadic communities with limited access to goods and services. The APHIA*plus* Northern Arid Lands zone stretched across four provinces and effectively incorporated three sub-regions: Turkana County; Upper Eastern province/Samburu (UES); and, North Eastern province/Tana River county (NEP/TR).

The Project operated in the following eight counties:

- Tana River
- Garissa
- Wajir
- Mandera
- Isiolo
- Marsabit
- Samburu
- Turkana

Innovative strategies were required to address the unique challenges faced by communities in this zone. Project activities occurred at both health facility and community levels and involved a high degree of collaboration with GoK partners and stakeholders at provincial and district levels.

The APHIA II NEP/APHIA*plus* NAL Project was funded at $25,753,517 over five years. Under APHIA II NEP, at least 90% of the designated funding was for HIV-related activities. Under APHIA*plus* NAL, the Project was to be allocated funding apportioned across its program areas as follows:

- MCH – 43%
- HIV/AIDS – 42%
- Family Planning – 15%
- Nutrition – 1%

While these were the intended allocations against which the annual work plan was developed, the actual funding received was:

- MCH – 5%
- HIV/AIDS – 82%
- FP – 12%
- Nutrition – 1%

The focus of this report is primarily on North Eastern province, for several reasons. NEP is the only geographic area which was focused on for the full five years of the Project. Therefore, it is easier to discern trends and show results against targets (although targets were revised – usually upwards – on an annual basis). The Project's duration of implementation in the expanded areas was only about 15 months, of which several months were consumed by start-up activities, including office establishment, recruitment of staff and procurement of equipment and supplies.

This report provides a PMP exclusively for NEP (Annex I) as well as a PMP for the 15 months or so that the Project was in NAL (Annex II). While certain conclusions are drawn for both NEP and NAL, readers are encouraged to review the respective PMPs for additional details on performance.

II. CONTRIBUTION TO HEALTH SERVICE DELIVERY

RESULT 3 – Increased Use of Quality Health Services, Products, and Information

3.1 HIV prevention and adoption of healthy behaviors

Comparison of accomplishments with goals and objectives

The primary focus of APHIA II NEP was to maintain low prevalence rates through reinforcing the influence of local religious and societal leaders around abstinence and being faithful and using them as culturally acceptable means for influencing the local population. However, PMTCT data from UNICEF's work in the region showed areas of rapid expansion of the epidemic mainly around Garissa (5% prevalence) and other urban centers which were acting as catalysts in fueling the spread of the HIV epidemic. Urban areas within NEP generally feature significant populations of civil servants, teachers, development administrators, uniformed services personnel and commercial traders, many of whom are from other regions of the country and are often unaccompanied by their spouses or families. There are also groups of single young men from NEP, for whom sexual activity is primarily through transactional sex with sex workers (many of whom may not identify themselves as such).

Despite the general perception of NEP as an Islamic province with conservative social morals, these urban centers featured "hot spots" for commercial sex and opportunities for the HIV virus to enter the mainstream population through informal/concurrent unions, widows and polygamous unions. For APHIA II NEP to develop an effective prevention strategy, it was critical to identify spaces where transmission could be taking place, or where effective communication strategies or other targeted prevention strategies could help to slow the epidemic.

PEPFAR indicators for HIV prevention which were utilized for APHIA II NEP were relatively unsophisticated and measured only outputs in the form of "numbers of individuals reached" with information about abstinence, being faithful or using condoms. The Project realized early on that while it would not be difficult to surpass targets for individuals reached (particularly since local culture was very supportive of abstinence and being faithful), it would be critical to have interventions which were evidence-based if the intended behavioral objectives were to be achieved.

APHIA II NEP therefore commissioned in early 2008 a Sexual Networks Assessment with the following objectives:

1. To obtain information on the location and level of risk behavior among key groups in Garissa and immediate surroundings.
2. To identify major or potential transmission routes between Nairobi and NEP, and potential target groups, locations and communication points for intervention.
3. To identify local gaps in HIV knowledge, behavior and practice that can be turned into intervention areas by APHIA II teams.

The assessment was the first of its kind in NEP and essentially confirmed anecdotal evidence and went beyond it in identifying specific groups and behaviors which required tailored interventions. Results indicated that Garissa was indeed similar to the rest of the country in that it had a diverse set of most-at-risk populations which required a correspondingly diverse set of prevention interventions and messages.

In April 2008, APHIA II NEP co-hosted, along with the MOH and several Islamic bodies, a conference for Islamic scholars on *Health and Islam in the Context of NEP*. Resource persons included internationally-recognized Islamic medical professionals as well as influential Islamic scholars. The turnout of participants was greater than planned, with over 60 people from throughout the province.

Objectives of the conference included:

- To establish an Islamic perspective on the issues of HIV/AIDS, reproductive health (including child spacing), TB and utilization of health services;
- To establish a common approach within the NEP community to improving maternal and child health;
- To socialize and integrate Islamic principles among the community to enhance behavioral change in relation to health matters;
- To establish a network of Muslim men, women, and youth attached to mosques at local and regional levels and use each mosque as a centre for health activities in relation to health promotion and prevention of communicable diseases and drug abuse; and,
- To develop a strategic plan of action and program of implementation at the community level that would strongly support and accelerate health promotion, safe motherhood, prevention of HIV and drug abuse among others.

Debate was lively and spirited, with issues of culture versus religion cutting across the various topics. Some participants expressed very conservative and uninformed opinions, suggesting for example that PLHIV should be physically segregated from the community and left to die. A local PLHIV who was also a conference participant revealed his status during the conference and gave a talk which brought the discussion from the conceptual to the personal level. Discussions on condoms brought many divergent opinions to the forefront. Local media interviewed participants, including the Provincial Medical Officer. On the last day, participants drew up action plans to take back to their districts.

Although consensus was not reached on all topics, the conference participants issued a list of 21 recommendations or resolutions, most of which directly supported the work that APHIA II NEP was doing (see Appendix X). In NEP, where Islamic leaders are so influential on matters of public concern, the importance of this list of resolutions cannot be over-emphasized.

Potential “champions” were identified, as well as a number of action steps for follow-up after the conference. Thanks to the support of Islamic leaders, targets for reaching individuals, particularly with messages promoting abstinence and/or being faithful, were easily surpassed. Networks of youth peer educators and the establishment and support of “*Chill* Clubs” at primary and secondary schools throughout the province also contributed to achievement of this target.

"Chill club" members in Garissa Girls Secondary School.

In 2009, the findings of the Garissa Sexual Networks Assessment were utilized by the Project to develop a behavior change strategy (*Twaweza, Tukiwa Pamoja*; translation: we can, if we are together) specific to NEP. The strategy identified and prioritized the key risk and protective behavior determinants for the most-at-risk populations that would be targeted by communication activities. The development of evidence-based, locally appropriate IEC messages and materials is a best practice which was ground-breaking in NEP. Guest of Honor at the official launching of the strategy in Garissa in August 2009 was the Chief Kadhi of Kenya, Sheikh Hammad Kassim; many influential sheikhs and imams participated in the launch, a strong indication of how significantly attitudes around HIV and AIDS in the province had changed in the two years since the Project had commenced.

Training of sex workers in Isiolo.

"One of us has HIV but we still love him"

Indicators became more evidence-based under APHIA*plus* NAL, but the approach of the Project continued to draw from lessons learned in NEP. The Project implemented Sexual Network Assessments in Isiolo and Lodwar in 2011. These were firsts in both localities and established evidence bases for prevention programming.

VMMC: APHIA*plus* NAL trained two dedicated teams to conduct activities in Turkana North and Turkana South. Delays in the implementation of this activity were caused by recruitment challenges and community relation issues with NRHS in Lodwar. However, the training of the teams was completed in February 2012 and operations commenced immediately after the training. Sensitization of community leaders in both Turkana North and South took place at the beginning of March. As at 30th April 2012, 406 male circumcisions had been performed. The teams were disengaged on April 30th and the supplies and equipment put in place for the incoming consortium to take over.

VMMC performed by APHIAplus NAL team in Lokichogio, Turkana county

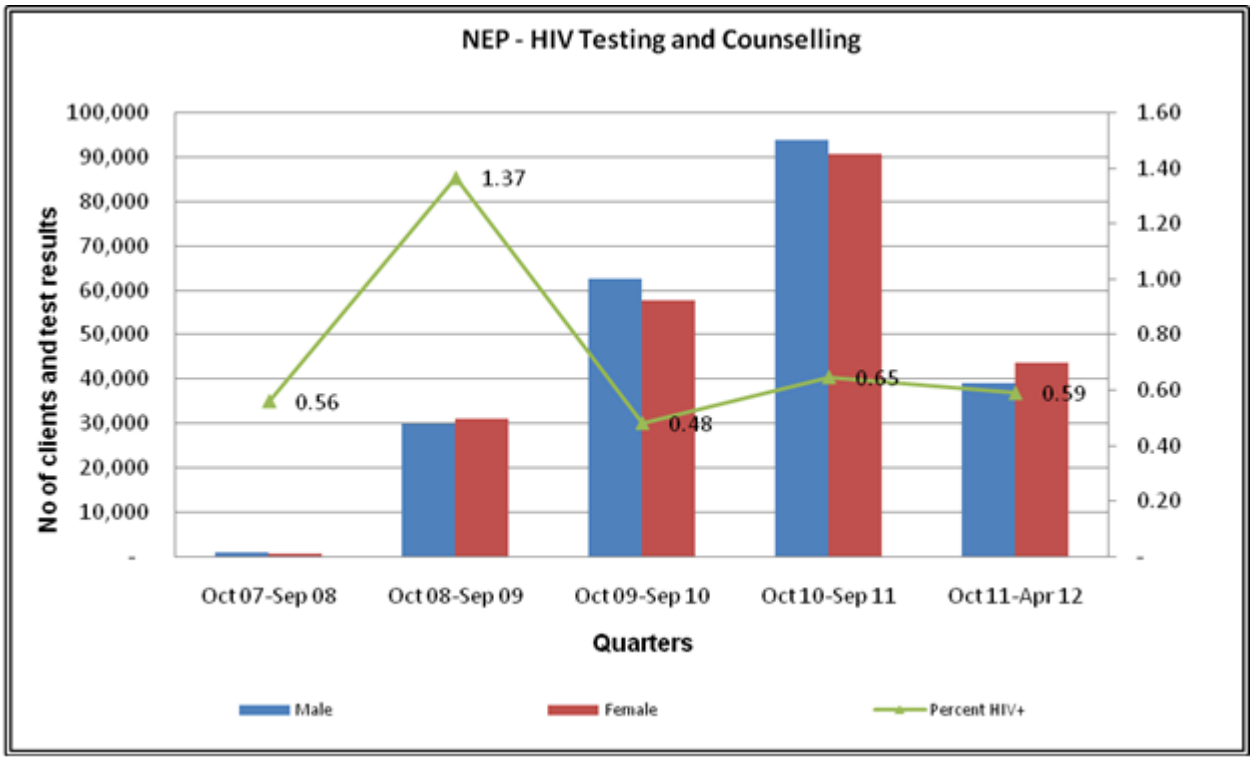
Lessons learned/recommendations

- Recruiting, training and posting VMMC clinical teams in remote areas of Turkana county is very challenging and took the Project several months to complete. These teams were just becoming fully operational when the Project was informed that it would be discontinued. The Project has strongly encouraged the incoming consortium to utilize the two existing VMMC teams rather than to start from afresh.
- Sex workers are a MARP present in many towns in NAL, but are particularly numerous in Isiolo town. The Project identified, trained and earned the trust of many Isiolo SWs. These SWs have special needs, including training on risk reduction, livelihood alternatives and the provision of dedicated clinical services for SWs because of the high levels of stigma which they face. The incoming consortium is encouraged to pick up where the Project left off and to expand coverage to towns such as Moyale, Lodwar and Mandera.
- Stigma is still persistent in some communities in NAL. Disclosure and denial remain obstacles. Some patients who are living with HIV travel to distant ART sites to collect their medications for fear of stigma at local CCCs. Stigma reduction initiatives should be strengthened: this includes health talks by expert patients during community meetings and at CCC clinics, community radio sessions and continued religious leaders talks in mosques, churches and community radio sessions. One of the roles of the religious leaders is to make home visits to critically ill clients to provide spiritual counseling and prayer. The incoming consortium should leverage existing constructive relationships with all of these groups.
- The Project supported the training of expert patients, one for each CCC. However, the work load is still very high because of increasing numbers of PLHIV who come for services. There is a need for adding staff to assist with the link desk work. Additional expert patients should be distributed to high-volume CCCs. They can be identified through the CCC in-charges because they know those who are influential and able to assist such initiatives.
- The Project did not manage to implement the anticipated Christian religious leaders' conference similar to the conference for Islamic leaders held in 2011. There is need for the incoming consortium to hold a conference for Christian religious leaders in order to reach the Christian community through their RLs. Similarly, the incoming consortium

should make use of the resolutions issued by Islamic leaders in Garissa and Isiolo following their Project-supported conferences in 2008 and 2011, respectively

3.2 HIV Counseling and Testing

Figure 1: Counseling and Testing Performance: NEP



With a general prevalence rate hovering around 1%, the HIV epidemic in NEP is unlike most of the rest of the country in that it is concentrated primarily among high-risk groups in urban or peri-urban areas. During the course of APHIA II NEP, the Project's strategy was to identify high-risk individuals and increase their access to HIV counseling and testing. Under APHIA*plus* NAL, Samburu and Turkana (and to some extent Tana River) counties required different approaches which took into account the generalized nature of the epidemic in those areas.

At the commencement of APHIA II NEP, there were very few VCT counselors in the province, working for the most part on a voluntary basis and with inadequate furniture, supplies, training and/or morale. With the support of APHIA II NEP, VCT counselors were recruited, hired, trained and posted. Concurrently, efforts were made to improve the work environment of the VCT sites, so as to improve confidentiality and comfort of clients.

Renovation of VCT center, Griftu DH, Wajir West - before

Renovation of VCT center, Griftu DH, Wajir West – after

Identification of MARPs was initiated by the Project with the Garissa sexual networks assessment which was implemented in early 2008 (see section 3.1 *HIV prevention and adoption of healthy behaviors*). The Project increased access by MARPs to counseling and testing services through a variety of approaches, including:

- Recruiting, hiring, training and posting of VCT counselors (through collaboration with the Capacity project) to selected high-volume sites;
- Ensuring adequate supplies of rapid test kits throughout the province by enhancing the skills of providers in commodities management and coordinating provision of commodities with the appropriate national mechanisms;
- Rolling out innovative CT approaches, including moonlight; house-to-house; and, mobile outreach;
- Development and use of locally-appropriate IEC materials and mass media messaging; and,
- Promotion of HIV prevention with positives, including assessment of partner status and provision of partner testing or referral for partner testing.

With the expansion to new geographical areas under APHIA*plus* NAL, the Project used the protocols developed in Garissa to implement sexual networks assessments in Isiolo and Lodwar towns and immediate surroundings. As with Garissa, this was a first for both areas and formed the evidence base for identifying MARPs and developing region-specific HCT strategies.

Clients with counselor during VCT outreach in Turkana county.

Comparison of accomplishments with goals and objectives

- Under APHIA II NEP, HCT gathered momentum by the beginning of Year 2, particularly following the Islamic scholars conference and with the initiation and support of national RRIs.
- HCT results by the end of Year 3 had surpassed 400% of target, despite targets being revised upwards in Year 2 and Year 3.
- HCT results continued to surpass targets in the expansion areas under APHIA*plus* NAL.

Lessons learned/recommendations

- Use of RLs and other influential opinion leaders was critical to increasing acceptance of HCT, particularly in NEP and other predominantly Muslim areas. A written statement of formal resolutions is particularly helpful in this regard (see Annex X).
- Innovative strategies and approaches must be employed in order to reach MARPs in highly stigmatized environments, as well as nomadic communities.

3.3 Palliative Care – TB/HIV

Table 1: TB indicators (NEP; May 2007 - May 2012)

NEP	Year 1	Year 1 target	Year 2	Year 2 target	Year 3	Year 3 target	Year 4	Year 4 target	Year 5	Year 5 target
TB cases detected			1,629		2,102		2,715		1,562	
Smear positive			1,094		765		890		548	
Smear negatives			1,592		1,367		1,788		1,243	
Extra-pulmonary TB patients on treatment			537		444		371		269	
TB patients on re-treatment			856		1,246		355		237	
TB Patients tested for HIV	335		1,946	800	1,746	1,200	2,129	1,500	1,074	350
TB Patients HIV+	21	160	252	450	277	600	128	600	57	120
TB HIV patients on CPT			382		407		136		60	
Defaulters			97		58		86		64	
TB patients completed treatment			1,366		1,097		1,463		715	
TB Deaths			57		55		87		34	

Comparison of accomplishments with goals and objectives

- The Project consistently surpassed its targets in NEP for testing of TB patients for HIV.
- For unknown reasons, co-infection rates for TB/HIV are consistently lower in NEP than the rest of the country and this is reflected in the Project results.

Lessons learned/recommendations

- Many labs in NAL are unable to offer basic lab investigations due to lack of space and reagents. This has impacted negatively on care and treatment. There is need for districts and counties to link to the relevant national mechanisms as soon as they are operationalized. Meanwhile, the support for strengthening CD4 networking and other lab services should continue.

3.4 HIV and AIDS treatment/ARV services

Table 2: Summary of ARV services in NEP

Indicators	Year 1	Year 1 target	Year 2	Year 2 target	Year 3	Year 3 target	Year 4	Year 4 target	Year 5	Year 5 target
Sites providing ART	**4**	**15**	**12**	**20**	**20**	**20**	**38**	**45**	**38**	45
Newly initiated on ARVs	51	1,200	267	550	232	400	249	750	182	175
Cumulative on ARVs	412	2,100	682	3,000	918	3,400	1,799	4,050	1,958	4,200
Currently on ARVs	400	2,000	544	2,750	810	3,150	1,483	3,800	1,618	3,950

Comparison of accomplishments with goals and objectives

- The Project greatly increased access to ART through the establishment of satellite ART sites throughout the region as well as training of service providers (under APHIA II NEP) and the networking of labs for CD4 (and other diagnostic tests). In NEP, ART services were only offered at the four district hospitals at the beginning of the Project, and quality of services was poor. By Year 4 of the Project, 38 sites in NEP were providing ART services.
- The Project implemented a mentorship program to develop the capacity of health workers already working in CCCs to give support to their peers to improve identification, assessment and management of both adult and pediatric clients in need of care and/or treatment. The Project collaborated with the Kenya Pediatric Association to roll out this program in support of NASCOP and the Ministries of Health.

Lab tech drawing blood at the Garissa PGH CCC laboratory

Lessons learned/recommendations

- Shortages of qualified health staff in NAL persist despite the arrival in late December 2011 of health workers recruited through the Capacity Project, as not all staff offered the positions accepted the offer. The Capacity Project will need to conduct additional interviews for replacement staff where staff recruited earlier did not turn up.
- Low capacity for initiation of ART services continues to hamper ART service provision in some health facilities due to lack of training in ART. The ART mentorship program rolled out in the reporting period will help in addressing this gap in the interim while the National Training Mechanism conducts needs assessments.
- Most HIV-positive OVC do not have permanent guardians who can ensure consistent and quality follow-up of ART treatment and services. The Project recommends that these OVC should be linked to the OVC/HBC programs through the CCC link persons so as to put in place follow-up mechanisms.

3.5 HIV care and support

Table 3: Summary of CHBC services in NEP

Indicators	Year 1	Year 2	Year 3	Year 4	Year 5	LOP
Clients served	-	-	517	1,396	1,559	1,559
Clients who died	-	-	12	14	7	33
Care givers	-	-	397	1,522	1,043	1,043
HBC clients (male)	-	-	155	496	576	576
HBC clients (female)	-	-	362	900	1,027	1,027
Clients on ARVs (male)	-	-	128	434	473	473
Clients on ARVs (female)	-	-	282	701	776	776
ARV clients dropped out	-	-	-	6	48	54
Referrals for VCT	-	-	223	450	846	1,519
Referrals for CCC	-	-	581	1,054	1,592	3,227
Referrals for FP	-	-	62	44	548	654
Referrals for nutrition	-	-	-	260	134	394
Referrals for support group	-	-	549	894	1,150	2,593
Referrals for PMTCT	-	-	51	44	248	343
Condoms distributed	-	-	2,070	7,247	14,259	23,576

Comparison of accomplishments with goals and objectives

When the Project commenced in 2007, there was one support group for PLHIV in the entire North Eastern province. The group was led by a Chairperson who was not HIV positive and had had its funding suspended by donors for alleged financial improprieties. It had very few members of whom fewer still had disclosed their status. Members from NEP could be counted on one hand.

The Project introduced treatment literacy training in Garissa in 2009 and it began to have an impact almost immediately. Participants were drawn from CCC registers and so were completely composed of PLHIV. Following the trainings, participants were encouraged to form

Post-Test Clubs (PTCs). Besides providing social support for members, the formation of functional PTCs allowed them to attract assistance in-cash and in-kind from various donors, including food supplies from the Office of the President. Members could be seen by the community to visibly improve in health and well-being, thanks to improved adherence and lifestyles. Islamic leaders, in line with the resolutions generated at the Islamic scholar conferences, would demonstrate their support and encouragement at the openings and closings of the treatment literacy courses. Increasing numbers of PLHIV who had completed the course and felt empowered by their knowledge began to disclose their status publicly, including many members of the Somali community. Demand for treatment literacy courses surged throughout NEP and the number of PTCs increased from 1 to 20, spread throughout the province.

The Project recognized early on the necessity to create a cohort of treatment literacy trainers who were from local communities in NEP. The first treatment literacy TOT was held in early 2010 and proved very successful in bolstering the skills of those PLHIV who were willing to disclose their status publicly and act as advocates for the rights of PLHIV. Following the TOT, local PLHIV began assisting with facilitation of treatment literacy courses and eventually began leading them.

Treatment Literacy training in Elwak, on the border with Somalia

The approaches for rolling out care and support in the rest of NAL were based on the experience of APHIA II NEP, but the other sub-regions also developed their own context-specific characteristics and strategies. The common thread has been the implementation of treatment literacy training and formation of PTCs as the foundations for empowering PLHIV and reducing stigma.

Lessons learned/recommendations

- The empowerment of a cohort of PLHIV advocates across the NAL zone represents an important achievement of the Project and one that should be leveraged and built upon by the

incoming consortium. They are a critical component to improving the lives of PLHIV in NAL and fighting stigma across the zone.

- Treatment literacy training has been the single most empowering intervention for PLHIV in NAL. The Project has developed a cadre of treatment literacy TOTs who are from the NAL region and who can lead or assist with the scaling up of training. The incoming consortium should make use of these valuable resource persons.
- There is need for continued counseling on substance abuse – particularly in Turkana, Samburu, Moyale and Mandera – and intensification of defaulter tracing with the help of local leaders, CHVs, caregivers and expert patients. Expert patients should also be supported to conduct outreaches for substance abusers. Use of reformed substance abusers as mentors is also important – the Project has used a number of these and the incoming consortium should consider them as resource persons.

3.6 Prevention of Mother-to-Child Transmission of HIV

Table 4: PMTCT cascade NEP

Indicators	Year 1	Target Year 1	Year 2	Target Year 2	Year 3	Target Year 3	Year 4	Target Year 4	Year 5	Target Year 5	LOP
Women starting ANC	12,233		30,142		29,760		30,206		12,752		115,093
Women attending ANC as revisits	16,393		34,307		38,830		42,162		17,701		149,393
Women counseled	12,233		30,674		32,348		32,619		13,384		121,258
Women who had HIV test	14,050	20,000	28,863	29,407	30,864	30,000	31,497	45,000	12,932	14,500	257,113
Women tested HIV +ve	61		99		106		82		37		385
Mothers given NVP at ANC	43	586	54	56	91	120	74	250	22	80	284
Infants tested for HIV after at 6WKS					41		51		7		99
Infants tested for HIV after at 3 months					36		56		8		100
Infants issued with preventive ARVs	9		10		59		68		17		163
Mothers tested at maternity	53		780		5,561		9,553		4,451		20,398
Deliveries	4,171		11,534		11,313		15,235		6,243		48,496

Comparison of accomplishments with goals and objectives

To achieve the objectives contributing to the reduction of MTCT of HIV and provide ongoing, comprehensive PMTCT services through integrated programs, Project activities were designed to revolve around certain key activities:

- Expanding services into new facilities, aimed at universal coverage in all GOK facilities offering ANC services;
- Facility renovations to increase space that facilitates privacy and confidentiality, both audio and visual;
- Improving internal referral linkages and supporting facilities to provide a comprehensive ANC package;
- Strengthening joint supportive supervision and providing technical assistance to DHMTs and service providers for project implementation and capacity building;
- Improving the quality of care of both facility and community services;
- Raising community awareness and demand for PMTCT services, including couple counseling and testing;
- Reducing stigma and linking HIV+ mothers to community support and follow-up; and,
- Enhancing monitoring and evaluation, including support for data management and utilization at facility and district level.

PMTCT continued to gain acceptance in all the three sub-regions of NAL. Although access to quality PMTCT services suffered from high turnover of skilled staff and other challenges, the availability of services to prevent vertical transmission of HIV, coupled with widespread acceptance of counseling and testing, was a critical achievement in NAL. Unlike five years ago in NEP when HIV testing in the antenatal clinic was viewed with suspicion, nowadays it is accepted as part of ANC and mothers who are not offered the service are at times known to demand why.

The Project's success in improving access to PMTCT services can be attributed to a multi-pronged strategy which includes training of providers, provision of furniture and equipment, supporting quarterly facilitative supervision, improving internal referral linkages and supporting facilities to provide a comprehensive antenatal package.

Lessons learned/recommendations

- In Turkana county, ANC attendance among pregnant mothers is relatively low and male involvement in PMTCT is still a challenge. This will require more work in developing a strategy that will bring men on board since it is known they are the decision makers on most health matters. CHVs and opinion leaders such as Laibons (medicine men; see picture in section 3.9) have indicated willingness to be supportive.
- ANC uptake, especially the 4th ANC visit, is still low in many facilities, attributed to high dropout rates and late enrollment for the service, often in the third trimester.
- Lack of G4S or other courier services in parts of NAL hampers transportation of EID samples. There is need to develop closer partnerships with local traders and the Post Office and support the DMLTs to transport DBS samples from remote locations to points where G4S services are available.

Maternal, newborn and child health/family planning

MNCH/FP is a priority program area in NAL. Maternal mortality remains unacceptably high in NAL with almost all of the deaths being the result of well-known and preventable causes such as hemorrhage, eclampsia, obstructed labor and puerperal sepsis.

Under APHIA II NEP, the Project leveraged HIV funds to address integrated services in innovative and cross-cutting ways, for example through the renovation of labs and establishment of a lab network. With the advent of APHIA*plus* NAL, MNCH/FP took on added emphasis.

Although MCH funding levels did not increase to the levels anticipated, this program area continued to receive emphasis through the innovative use of HIV funding.

Assessments by the Project across the region identified a constellation of cross-cutting **challenges** that define the region:

Socio-cultural challenges – NAL is mainly inhabited by nomadic pastoralist communities which have maintained their traditional cultures. More than half of the population, concentrated primarily in NEP/TR and Upper Eastern, professes to the Islamic religion. A number of cultural and religious beliefs have significantly contributed to poor MNCH health-seeking behaviors and health outcomes. Among the Somali and Borana community, for example, pregnant mothers are expected to immediately go into seclusion for 40 days following delivery. This encourages home delivery by TBAs and impedes targeted postnatal care. The Islamic and Catholic faiths support utilization of the less efficacious natural family planning methods but strongly discourage usage of conventional and modern family planning services for healthy timing and spacing of pregnancy. This religious dictum has led to low uptake of family planning services. The preference of women in Turkana county to give birth in a squatting position has discouraged them from seeking deliveries with service providers for whom squatting is seen as foreign. The almost universal practice of FGM in the region (apart from Turkana County), coupled with early marriages, contributes significantly to negative maternal health outcomes as well as obstetric fistulas.

Spatial challenges – Distances to health facilities in NAL average 50 kilometers and are often considerably farther. Paved roads and reliable public transportation are a rarity. This significantly limits access to health care, especially when taking into account the harsh climatic conditions (hot sun and rough terrain alternating with flooded roads during rainy seasons). Most of the Level 4 health facilities are yet to attain comprehensive emergency obstetric care status. The vast distances and poor roads discourage referrals for obstetric complications and have a direct and detrimental effect on treatment outcomes.

Economic challenges – Public health facilities at level 2 and 3 have statutory exemptions for maternal and child health; however, some form of financial expenditure is required to cover procurement of supplies and transport. Furthermore, most health facilities have standard charges for laboratory diagnoses. In this zone, where livestock rearing remains the main source of livelihood, the measures of poverty are sobering, with the absolute poverty level at 65% in 1994 and 73% by 2000. Vision 2030 reported in its section on the Northern Arid Lands that half of Turkana could see their livelihoods improve 1000% and still not reach the poverty threshold.

Personnel, equipment and infrastructure challenges – Difficulties in attracting, hiring and retaining skilled health staff in the region hampers the attainment of adequate and sustained capacity for delivery of high-quality health services. A significant percentage of health staff manning peripheral facilities are contract employees hired by development partners or special GOK programs such as the Economic Stimulus Program – they require frequent and timely updates to offer comprehensive health services. Preference by clients for female health care workers during antenatal and delivery services also reduces access to services. Majority of the health facilities lack basic medical equipment to offer quality MNCH/FP services; these include EmOC, FP and cold chain equipment for EPI. Additionally, the inadequate and often rudimentary referral infrastructure often delays obstetric referrals and contributes to negative maternal outcomes.

Demographic challenges – Fertility rates across the region are quite high, averaging 6 children per household. This is coupled by low contraceptive prevalence at 3.5% (NEP; KDHS 2008/9). NAL performs poorly in terms of education, a powerful social determinant of health, particularly

acceptance of modern methods of family planning. Primary school enrollment, measured by net enrollment rate (NER) lags significantly behind the national average of 91%. NER is 66% in Samburu and Turkana, and below 10% in NEP. Transition to secondary school and retention rates are poor, with only about 5% of learners going to secondary school, and drop-out rates as high as 18% in Turkana (the national rate is 3.5%). 2007 data show only 42% of students complete primary school. Girls' access to school, retention, and exam results are all worse than boys'.

In response to this unique constellation of challenges, the Project developed MNCH/FP **strategies** to assist the MOH and communities to address and mitigate them:

Partnerships with influential gatekeepers – Strategic partnerships with traditional gatekeepers can leverage the significant influence these individuals and institutions have in NAL. In these situations, the existence of deeply rooted cultures and adherence to traditions can become an opportunity. APHIA*plus* NAL established strategic partnerships with religious leaders and community structures – Islamic leaders in NEP, Tana River and Upper Eastern; elders in Turkana; morans in Samburu; and other key gatekeepers in the rest of the zone – to remove negative barriers and advocated for increased uptake of high-impact maternal, newborn and child health services.

Integrated outreach services – Outreach models targeting the hard-to-reach and underserved populations which constitute much of NAL can effectively increase access to and utilization of health services. The outreach model supported by APHIA*plus* NAL was mainly motor-bike supplemented with vehicle-based outreaches and nomadic clinics in specific areas. APHIA*plus* NAL supported outreach services by providing logistics, training and guidance on the minimum care package in the outreach sites.

Laboratory networking – Laboratory networking directly addressed the spatial challenges to providing critical diagnostic services for remote populations. It also greatly reduced the costs associated with having to travel to the point at which diagnostic services are offered. The Project supported clients in the vicinity of peripheral facilities to access referral laboratory services for CD4, EID and ANC profiles.

Smart integration - The Project supported health service smart integration to leverage support for health care needs and maximize outputs. Specific emphasis was laid on high-quality, high-impact and low-cost interventions to improve uptake of service delivery. Service integration promoted a '***one-stop shop***' approach for key target populations such as youth, women of reproductive age and children. Service delivery points and/or program areas targeted included MCH, FP, HIV, YFS and postnatal care.

MOH resource envelope – The Project provided the MOH with monthly district-level resource envelopes which the MOH can draw on to fill critical gaps and implement activities which fall within the mandate of APHIA*plus*. The sharing of this information prior to the district AOP development process enabled districts to develop AOPs which were feasible in terms of support anticipated from APHIA*plus* NAL. APHIA*plus* technical staff worked closely with districts during the development and consolidation of their AOPs to ensure that support anticipated from APHIA*plus* NAL was realistic, consistent with the APHIA*plus* service delivery mandate, complementary to support received from GOK and other partners, and contributing to APHIA*plus* NAL programmatic targets – particularly MNCH/FP targets.

Evidence-based, high-impact interventions – Emphasis was on increasing access to and utilization of cost-effective high-impact interventions, including strengthening:

- focused ANC (assessing any risk factors);

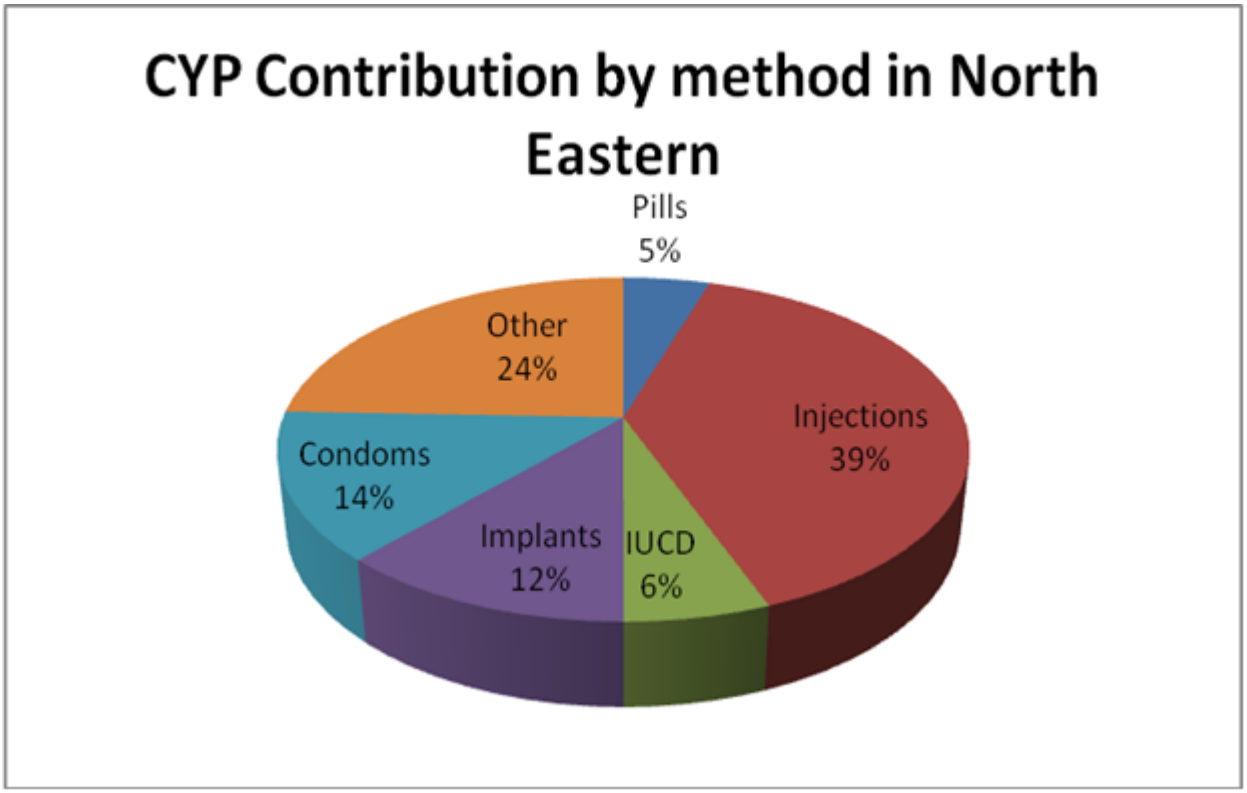
- ANC services (encouraging 4 visits, individualized birth plans and emergency preparedness prevention and management of pregnancy complications, including nutrition counseling);
- Labor and delivery (safe delivery kits for facility delivery, EmOC, active management of the third stage of labor, and use of a partograph to monitor labor);
- Postnatal care services (management of PPH with oxytocin, skilled attendance within 24-48 hours of birth, LAPM, and review of maternal and perinatal deaths);
- Counseling women/families on healthy timing and spacing of pregnancies;
- Early and exclusive breastfeeding to support newborn outcomes, reduce hemorrhage, and promote infant health;
- Immunization coverage at the district level; and,
- Community-based treatment of pneumonia, diarrhea and malaria.

3.7 Family Planning

Table 5: Summary of FP methods provided in NEP

Method		Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Pills		998	3,506	4,976	4,702	2,567	16,749
Injections	Injections	1,648	7,559	9,672	10,251	7,209	36,339
I.U.C.D	Insertion	28	43	46	62	108	287
Implants (no revisit)	Insertion	82	287	274	272	167	1,082
Sterilization	B.T.L	0	0	0	0	0	0
	Vasectomy	0	0	0	0	0	0
Condoms	clients receiving	2,991	10,406	11,797	9,093	4,010	38,297
ALL OTHERS: (Cycle Beads) (no revisit)		28	520	1,168	1,867	173	3,756
Total Clients		5,761	22,321	27,933	26,247	14,234	96,510
CYP Target		**1,000**	**1,500**	**2,000**	**7,000**	**2,000**	
CYP achievement		**1,292**	**3,212**	**4,686**	**7,071**	**3,397**	

Figure 2: Contribution to CYP by contraceptive method in NEP



Comparison of accomplishments with goals and objectives

- The Project consistently surpassed its original and revised CYP targets.
- The community in NEP is pro-natalist and family planning is generally viewed negatively. However, there is more receptivity to the concept of healthy timing and spacing of pregnancies in order to improve the health of both the mother and child, a concept in accordance with Islamic teachings. In fact, during the conference for Islamic leaders from NEP held in 2008, the following resolution in support of child spacing was arrived at:

  The Scholars resolved that planning pregnancies and spacing of births for the promotion of mothers and babies' health allow the use of all permissible and safe methods of contraceptives.

- The Project piloted the Standard Days Method in Ijara district as a method of pregnancy spacing. There was a common vision and close collaboration between local MOH officials and APHIA II NEP staff on introducing SDM as part of pregnancy spacing services. APHIA II NEP also engaged religious leaders in discussions on increasing awareness of the SDM as a modern method, which contributed to high social acceptance in Ijara district. The significant contribution of SDM to CYP was a clear indicator that the method was not only acceptable but popular. Based on the performance in Ijara, the Project procured CycleBeads and rolled out the method to other districts in the province and NAL using the same approach.

Discussing SDM using CycleBeads with Laibons (traditional leaders) in Turkana county

Lessons learned/recommendations

- Religious and cultural barriers still play a major role in discouraging women from practicing child spacing in all the three sub-regions. Advocacy must continue with influential opinion leaders, taking into account cultural sensitivities.

3.8 Nutrition

Comparison of accomplishments with goals and objectives

- APHIA*plus* NAL's approach to nutrition was to provide support for the scaling-up of Kenya's high-impact nutrition interventions through facility-based, community-level and outreach interventions. The magnitude of financial resources allocated to APHIA*plus* NAL by USAID (1% of total funding) for nutrition interventions was greatly outweighed by the needs on the ground. The Project therefore identified opportunities to advocate for and leverage the nutrition resources of other partners on the ground.
- One such initiative was the initiation of new Food By Prescription (FBP) satellite sites with the support of the USAID-funded Nutrition and HIV Project (NHP). In September 2011, APHIA*plus* NAL and NHP agreed on the respective roles and responsibilities of the two projects in rolling out FBP to primary and satellite sites meeting agreed-upon criteria. The purpose of this collaboration was to expand access to these services to marginalized and remote populations in need. An MOU describing the collaboration between NHP and APHIA*plus* NAL can be found in Annex X. APHIA*plus* NAL identified sites meeting minimum criteria, ensured delivery of supplemental and therapeutic food commodities and *WaterGuard* to the trained sites and initiated monitoring of the distribution. The Project also established linkages between CBOs such as post-test clubs and NHP in order to generate demand for the FBP services being offered. In NEP, for example, FBP was rolled out in Mandera, Masalani, Takaba, Habaswein and Elwak DHs.

In UES, the Project supported the establishment of FBP services in Samburu East DH; Samburu North DH; Marsabit DH; Moyale DH; and, Tumaini clinic in Marsabit. These are some of the hardest-to-reach high-volume sites and go far beyond NHP's initial plan to only reach Garissa PGH. Ongoing support to other high-volume health facilities in NEP and other sub-regions continued, focusing on nutritional support for malnourished, lactating mothers and children.

- APHIA*plus* NAL supported DNOs/DPHNs to conduct support supervision for *Malezi Bora*, enabling health workers to provide accelerated health education and counseling on HINI and other YCF practices.
- APHIA*plus* NAL established or revived ORT corners in high-volume facilities in each sub-region. In Turkana county, for example, ORT corners were revived at Kaputir dispensary, Lokori HC, Elelea dispensary and Lokichar RCEA HC.

Lessons learned/recommendations

- There continues to be a shortage of nutrition officers in the districts. Capacity Project and UNICEF have played a major role in addressing HRH gaps in NAL, but more needs to be done.
- The potential exists for expanding the number of FBP sites in the districts. There is need to open up more central sites and support additional satellite sites in order to expand access to this service throughout the zone.

3.9 OVC

Support to OVC was a high-profile aspect of APHIA*plus* NAL's work which was greatly appreciated by the local communities, particularly those located in extremely isolated areas who were rarely assisted by outside agencies. The project implemented OVC activities in close collaboration with the Ministry of Gender and Department of Children's Services at district and provincial levels, as well as other stakeholders working in the region. The program provided support to OVC in some of the most remote, difficult to reach and therefore frequently neglected areas.

Perhaps because of the nomadic lifestyles of its inhabitants, care for orphans in NEP has traditionally been provided through institutional orphanages. These orphanages have usually been run by Muslim charities which received much of their funding from the Middle Eastern countries. This funding dried up in recent years, but the local institutions had weak systems for attracting funding from other donors and were limited in their abilities to raise significant funding locally. Because of their relatively weak financial and administrative systems, the Project worked with most of these local partners by funding interventions directly (as opposed to providing sub-grants) after a needs assessment was carried out in close collaboration with the Children's Department. By the end of Year 2, the Project placed emphasis on building the capacity of its partners to provide support to OVC, particularly girls, within the surrounding communities rather than in institutional settings. The Project also increasingly identified and supported OVC through the PLHIV post-test clubs which it was building the capacity of.

In NEP, the Project initiated a system of waivers for OVC seeking health services in GOK facilities. APHIA*plus* NAL facilitated discussions between Locational OVC Committees and Facility Management Committees to discuss how community-based OVC can access health care services. In each facility the special healthcare and nutritional needs of the OVC were discussed, including barriers (e.g. lack of information on the existing services, especially nutritional) and ways of mitigating the barriers. Lists of eligible OVC were shared with health facility staff in order to help them identify those OVC whom the Project supports.

Different approaches for providing comprehensive support were implemented according to the programming context in each sub-region of NAL. Upper Eastern and Samburu utilized the extensive presence of Voluntary Children's Officers, for example, while in Tana River the Project channeled support through Social Workers and orphanages. In each of the sub-regions, the underlying foundation of the programming was to establish and/or strengthen GOK-sanctioned OVC bodies, particularly AACs and LOCs. While this process was time-consuming, it contributed to the potential sustainability of interventions and resulted in local resources which could be utilized for OVC support going forward.

Table 6: Support for OVC in NEP (including Tana River years 4-5)

	Year 1	Year 1 target	Year 2	Year 2 target	Year 3	Year 3 target	Year 4	Year 5	
Indicators	Oct 07-Sep 08		Oct 08-Sep 09		Oct 09 - Sep 10		Oct 10 - Sep 11	Oct 11-Apr 12	**Totals**
Number of OVC served	3,615	4,450	6,790	5,500	11,407	14,950	11,507	16,064	**16,064**
Male	2,906		4,445		7,095		7,157	9,716	**9,716**
Female	709		2,345		4,312		4,350	6,448	**6,448**
Number of individuals trained	409	400	334	500	251	500	147	30	**2,571**

Table 7: Support for OVC in UES and Turkana (January 2011- April 2012)

No of OVC supported	Jan-Dec 2011	Jan-Apr 2012
Male	8,761	8,761
Female	7,730	7,730
Totals	16,491	16,491

Provision of wheelchairs to handicapped children at Garissa Special School

Lessons learned/recommendations

- The Project has put great emphasis on establishing, working through and building the capacity of local, GOK-approved institutions dealing with OVC, including AACs, LOCs and VCOs. As a result, a great deal of latent capacity is being left in place which was not there previously. These institutional structures have the potential to be tremendous resources to any external agencies supporting OVC and the incoming consortium is strongly encouraged to make use of them.
- Batch processing of birth certificate applications has proven a cost-effective method. The incoming consortium is encouraged to establish relationships with District Registrars and employ the same methodology in order to address the huge backlog of OVC in NAL who are lacking birth certificates.
- Abundance of harmful cultural practices, especially early marriages and FGM, and inadequate IEC materials for continued advocacy and sensitization have continued to undermine OVC protection efforts for girls and other OVC. Project recommendation is for continued engagement, training and discussion with key community stakeholders, opinion leaders and custodians of culture such as circumcisers, TBAs, and RLs to help them understand the dangers of such practices. The RLs and provincial/county administration should also continue with strong advocacy for solutions to these challenges.

III. CONTRIBUTION TO HEALTH SYSTEMS STRENGTHENING

Description of the work plan status

The Project implemented a number of health system strengthening activities across the region. These interventions fell within the following categories:

- Health Leadership, Governance and Policy
- Human Resources for Health
- Health Financing
- Health Commodities and Equipment
- Health Information
- Health Service Delivery (covered mostly by the previous sections of this report)

Strategic Approaches

- Systems performance gaps assessments through supportive supervision and prioritization of needed actions at various service delivery levels and or through linkages with the national mechanisms, other development partners and local implementing partners.
- Use of evidence-based interventions in programming.
- Development and disbursement of monthly district health financing resource envelopes in the Project-supported districts to support the implementation of the AOP 6/7 activities.
- Active engagement of the DHMTs in strengthening DHSFs as key resource mobilization vehicles to address AOP financing gaps.
- Supporting the DHMTs/HMTs to provide supportive supervision for district and rural facilities and in planning and executing integrated outreaches.
- Supporting monthly facility in-charges data dissemination meetings that incorporate CMEs, TA and OJT to address various priority staff capacity and service quality gaps.
- Supporting hospital interdepartmental meetings and technical collaborative meetings aimed at skills and knowledge transfer and development of smart solutions to complex challenges.
- Supporting PHMTs to provide facilitative supervision for the national Malezi Bora campaigns.
- Focusing on and strategic involvement of MARPs and community opinion shapers in prevention interventions.
- Dissemination of the MoH service charters during community trainings and sensitization meetings to help in enhancing community awareness and confidence in demanding for quality and affordable services.
- Strengthening linkages between the communities and facilities through CHVs refresher training and CHCs orientation meetings within the CUs supported by the Project.
- The Project built partnerships and linkages with national mechanisms for result 1 and 2 activities and other development partners and local implementing partners for result 3 and 4 activities. The section below describes the partners that the Project has been able to link to and collaborate with in the course of the reporting quarter.

Systems strengthening activities

Health Leadership, Governance and Policy

- Supported facilitative supervision by PHMTs and DHMTs to address performance and quality gaps. Supported PHMTs in support supervision for lab networking for CD4, biochemistry and hematology diagnostics.

- Involved DHMTs in planning and execution of integrated outreaches at sites across NAL.
- Provided TA, supported and involved the DHMTs in the planning and implementation of DHSFs and collaborated with other partners for effective implementation of result 4 activities in various districts.
- Supported DHMTs to conduct biannual performance reviews of the AOPs.
- Supported facility governance improvement by working with Facility Management Committees and sponsoring OJT on project planning and management for local implementing partners.
- Distributed the School Health Policy guidelines through the District Education Officers.

Human Resources for Health

- Conducted the first ever HRH assessment in NEP.
- Collaborated with Capacity Project to recruit and post hundreds of health workers in order to fill critical gaps.
- Supported monthly facility I/Cs meetings for the purpose of data dissemination, CMEs, TA, OJT and performance monitoring. There has been significant improvement in service delivery as a result of addressing staff knowledge and skills gaps using these interventions.
- OJT, CMEs and TA conducted in the district hospitals to increase service uptake and to build skills of the healthcare workers.

Health Financing

- The Project provided resource envelopes (Kshs 200,000/month) to the DHMTs and PHMTs to implement prioritized AOP activities. The resource envelope approach to capacity building proved popular with MOH counterparts as it allowed them to plan with reliable resources and according to their own priorities – as long as they fell within the Project mandate and had been included in the AOPs. There is evidence that the use of the resource envelopes also contributed to the abilities of DHMTs and PHMTs to plan and implement activities.
- Supported a performance-based financing pilot activity for maternal and child health in Samburu District, in collaboration with MOH, World Bank and Population Council. The Project's role was as a verification body. The Project also supported and participated in a workshop in Maralal for field-testing PBF verification tools.

Piloting of PBF verification tools in Maralal, Samburu county

- Selected DHMTs allocated their own resources for supporting integrated outreach models piloted by APHIA*plus* NAL. For example, Samburu county and Marsabit South DHMTs continued to support public and FBO-based partner facilities to implement much needed integrated outreaches. These included: DHMT Samburu East Kshs 35,000 allocation per month to West Gate Conservancy to carry out 6 integrated outreaches; Samburu North DHMT Kshs 72,000 allocation per month to Arsim Lutheran Church for integrated outreach to 4 sites and Laisamis DHMT Kshs 40,000 allocation to Illuat Lutheran dispensary to implement integrated outreach at 4 sites.

Health Commodities and Equipment

- Linked and collaborated with national mechanisms for supply of commodities, including HCM for BCP and IEC materials, SCMS for stabilizer tubes, NHP for food by prescription.
- Strengthened delivery of commodities/drugs to the facilities through provision of logistical support.
- Reduced stock out of commodities through provision of OJTs/TA to facility I/Cs on commodities management.

Health information

- Supported monthly facility I/C's meetings for the purpose of identifying facility data gaps, analyzing performance, building capacity for addressing gaps identified and performance and quality improvement. The Project provided and supported provision of CMEs, TA and OJT on use of data for decision making and quality improvement. This improved timeliness, quality and consistent submission of data from facility to district, provincial and national levels.
- Supported training of DHRIOs and facility in-charges on the new NASCOP tools and DHIS.

- APHIA*plus* NAL provided logistical support for the distribution and dissemination of various facility data reporting tools and/or provided supportive supervision on the proper use of the reporting tools.

Health Service Delivery (covered mostly by the previous sections of this report)

- Supported interdepartmental meetings in the district hospitals for the purpose of strengthening linkages within and between departments.
- Support for integrated outreach services to increase access to and utilization of services by remote communities.
- MDR committee formation at the facility level, leading to community involvement and ownership.
- Quality and performance improvement through support supervision from the DHMTs to the facilities.
- APHIA*plus* NAL assisted Lodwar District Hospital to implement a customer satisfaction survey. This will contribute to the hospital's quality improvement strategy.

Linkages with national mechanisms and other programs

- Coordinated with NHP for provision of FBP and training of CHVs in each of the sub-regions. Creation of satellite sites brought FBP closer to remote communities through logistic support and training.
- Linked the facilities (ARV and PMTCT sites) and the district hospitals with Kenya Pharma for ARV and OI drug supplies.
- Coordinated with Capacity Project to monitor placement and performance of staff hired on behalf of the MOH in NAL.
- The co-location of a Program Officer from HCSM in Isiolo improved collaboration and networking of health facilities to SCMS and Kenya Pharma for improved supply of test kits, ARV prophylaxis and other commodities.
- Co-location of two program staff from HCM in Garissa resulted in close coordination and synchronicity between the two projects.
- Worked closely with Ministry of Public Health and Sanitation and Ministry of Education on establishing or strengthening school health programs.
- Linked facilities to SCMS for supply of HCT and lab commodities.
- Collaborated with NRHS and mobilized clients for VMMC service provision in Loiyangalani.
- Link to IMC in Isiolo for supplementary feeding and outreaches.

IV. MONITORING AND EVALUATION

Capacity building for the use of data for decision-making was integral to the APHIA*plus* NAL health system strengthening strategy. Working at the facility-, district-, and province-level, APHIA*plus* NAL partners laid the physical, systematic, and human resource foundation for meaningful monitoring to advance quality service delivery in its target areas. This technical brief discusses the project's approach to strategic health information capacity building, and provides recommendations for future such efforts in similar contexts.

Approach

Assessing Need

To better understand the capacity of the local health system, at project start the APHIA*plus* NAL partners conducted an assessment of 71 of NEP's 86 high volume facilities. As part of the assessment, the partners prioritized analysis of local data systems. National reporting rates indicated a gap in the province's performance monitoring capacity—over a three month period, 28 of the province's high volume facilities had reported on time, a reporting rate of just 32 percent. Assessment results demonstrated shortages of staffing and insufficient training, each of which strained capacity for service provision and monitoring. In 2008, over 30 percent of facilities were closed due to lack of sufficient skilled staff.

Though national guidelines designated one dedicated health and records officer per district, only four of the province's 11 districts had any such officer hired. With each of the officers already managing the records of 25 facilities on average, and facility level staff having received minimal training to collect and maintain data, the partners found that NEP lacked the resources needed to execute even its most basic monitoring responsibilities. To ensure their catchment area was sufficiently wide to make province-level impact, the partners set a target to cover over 80 percent of high volume health facilities in the province.

Strategic Priorities

To design their capacity-building strategy, APHIA*plus* NAL partners prioritized alignment with existing local and national public sector processes. The below discusses key areas with which the partners sought to align their efforts.

Performance Management and Accountability Structures

At the time of project start, the national reporting structure in Kenya was organized such that data was collected at the facility level, aggregated by District Health and Records Officers (DHRIOs) at the district level, submitted to the province level, and finally aggregated and submitted to the national level for distribution to relevant offices. Though the structure was intended to monitor service delivery quality, it lacked any formal mechanism to enable feedback between health system levels. Recognizing this gap, the partners designed their intervention to supplement the existing structure with mechanisms for routine dialogue about performance. Figure 2 illustrates the reporting structure in place at project start, and the process adjustments the partners sought to make.

Data infrastructure

Where data was collected strictly by paper in 2008, in 2009 the GoK introduced a new File Transfer Protocol to enable facility- and district-level web-based reporting. As the new process got underway, availability of internet connectivity, software, and computer equipment became critical to facilities' transition to electronic reporting. To address these needs, the partners planned to target NEP's six Comprehensive Care Clinics (CCCs), supplementing the government's supply of necessary resources, and training all relevant CCC staff to enter and maintain data using the new equipment. Recognizing that electricity shortages and inconsistent funds for internet connectivity would likely continue to deter

electronic reporting in the province, the partners emphasized a hybrid data maintenance process. CCCs were supported to coordinate their use of both electronic and paper-based records, thus ensuring an effective data system regardless of electricity outages or other barriers. The remaining facilities in NEP were supported to improve their management of paper-based records systems.

Alignment & utilization of Kenya's national systems
Throughout the project, APHIA*plus* NAL partners stressed the importance of adaptation to Kenya's changing health information system context. At project start, the 2008 File Transfer Protocol system introduced many facilities to electronic reporting methods for the first time. By 2010, a new national health information system (HIS) brought facilities and districts to again adopt new reporting processes (Luoma 2010), and by 2011, new national monitoring and evaluation goals presented further cause for procedural updates. Recognizing the ambitions of the GoK to modernize and streamline data systems, the partners prioritized timely and responsive support as facilities and districts adjusted to evolving national systems.

Implementation
APHIAPlus NAL prioritized two core focus areas in implementation: accuracy of data records and analysis, and accountability for data use..

Improving Data Accuracy & Analysis

Facility-level efforts
Data collection The partners undertook efforts in each of the district facilities to ensure proper data collection practices, first prioritizing CCCs. As the health facility assessment had found, the government form used to capture a patient's personal information, service uptake, and clinical assessment records was inconsistently used across district facilities. Without proper use of these forms, clinic registers and subsequent facility service delivery data were unreliable records of performance. To address the issue, the partners first ensured adequate supply of the forms throughout the districts, allocating funds to stock both the province's public and private clinics. The partners then engaged the region's DHRIOs to conduct data collection and records-keeping training for all relevant facility staff dealing with data. In this way, DHRIOs were familiarized with their facilities' data collection capacity as they trained them in the skills necessary for data management improvements.

Staff sensitization Stigma and discrimination toward PLHIV among facility providers contributed to the inconsistencies in record-keeping observed across NEP facilities. As a part of the project's larger efforts to strengthen HIV services, the partners and DHRIOs brought together doctors, nurses, clinicians, and administrators in each district for sensitization training using national curriculum. To ensure that the implications for data collection were addressed during this time, APHIA*plus* NAL adapted the curriculum to include focused practice on correct data entry processes for all patients, including PLHIV. Training participants received follow-up support to maintain their data skills through DHRIOs' supportive supervision visits, and the project's on-the-job training efforts.

District-level efforts
Project efforts began with a focus on ensuring human resource capacity. To address the shortage of data officers, APHIA*plus* NAL leveraged its partnership with IntraHealth to engage the Capacity Project. As an existing IntraHealth program supporting the national health workforce, the Capacity Project facilitated the hiring of seven DHRIOs in NEP, thus ensuring that each district had one full time data manager on staff. With this, the districts

gained the critical staffing that would be required to sustain their evolving data collection and monitoring systems.

Data reconstruction To ensure district-level capacity to maintain quality data sets, the partners undertook data reconstruction efforts throughout the region. To begin, APHIAPlus NAL provided training in basic data maintenance skills to all DHRIOs, reviewing facilities' service registers together to identify data entry errors. Where errors were identified, DHRIOs were taught data cleaning procedures to rectify discrepancies and ensure accurate facility data sets. DHRIOs thus gained critical skills to support their review of facility performance reports, at the same time that facilities gained accurate service delivery records.

Monitoring Progress to Targets Because facilities' data reporting had been relatively erratic at the start of project efforts, the first step in assurance of quality analysis was to routinize district supervisors' use of national targets to measure their facilities' performance. To support DHRIOs to more readily identify district performance gaps, APHIA*plus* NAL partners developed a user-friendly data entry and analysis module. A simple excel spreadsheet, tabs within the sheet delineated family planning, MCH, PMTCT, STI, TB, safe delivery, and VCT service uptake aggregates across a district's facilities. By providing automatically generated district summaries for the DHRIOs, the sheet enabled district supervisors to quickly and routinely monitor facilities' progress toward completion of targets, and identify problem areas for follow-up. Until this point, performance review against national standards had been a rare event, typically conducted by outside stakeholders. For many DHRIOs, the module supported supervisors' target-based monitoring for the first time.

Analyzing Complete Service Delivery The partners also emphasized districts 'performance analysis beyond target-based monitoring. As a first step in supporting districts to conduct this type of analysis, the partners reviewed facilities' HIS indicators to identify pairs of data that, when compared against each other, could provide insight into the completeness of the package of services being received by clients. To monitor facilities' performance in linking PLHIV to treatment, for example, DHRIOs began regularly comparing facilities' reported number of clients testing HIV positive to the number of clients having initiated anti-retroviral treatment (ART).

Building Accountability for Data Use

Sustainability was a primary goal of APHIA*plus* NAL's data capacity-building efforts. As a result, the partners prioritized institutional solutions to build accountability for data use.

Quarterly Feedback Sessions

Because the region's existing reporting structure did not provide a platform for dialogue about performance, the partners worked with the regional health sector to introduce one. Already, APHIA*plus* NAL conducted its own internal quarterly performance reviews, in which DHRIOs participated. As these key players were thus familiar with the process, the partners proposed that DHRIOs adapt the quarterly reviews for use in their districts. Beginning in 2009, APHIA*plus* NAL staff joined DHRIOs as they led provincial officers, district counterparts, and facility managers in review of facility performance. A day-long meeting, the reviews included discussion of facilities' progress toward national targets, as well as their quality and completeness of services delivered. Because facilities were publically compared and ranked by performance at these sessions, many DHRIOs reported a sense of competition for performance improvement developing between facilities.

Data Quality Audits

To bolster facilities' continued quality maintenance of service delivery records, the partners supported DHRIOs to initiate data quality audits. Conducted at randomly selected facilities,

these audits brought together facility data clerks, district and facility managers, and DHRIOs to review data sets and records management procedures. Audits prioritized identification of data entry errors such as discrepancies between quarterly performance reports and facility service records, as well as duplicate entries and missing client information. DHRIOs then included results of these audits in quarterly review meetings, while providing formal recommendations to facility managers for relevant data system improvements.

Lessons Learned/Recommendations

Hybrid data systems key for resource-limited settings Longitudinal analysis of service delivery performance is an important part of the quality improvement process, enabling supervisors to see trends over time and identify need for targeted interventions. In the APHIA*plus* NAL context, efforts to introduce longitudinal analyses were hampered by paper-based records systems in which individual patient records were required to be transferred to a new register every 24 months, thus introducing ample room for error and making continuous tracking of trends in service uptake difficult. In situations like NEP's, where a complete transition to electronic data systems was not possible due to resource constraints, prioritizing the service delivery posts most likely to impact key quality improvement goals may be an effective approach. By targeting the CCCs in NEP for electronic system adoption, while supporting the remaining facilities to maintain quality paper-based records, the project was better able to cover its entire catchment area while targeting the highest leverage facilities for the most immediately necessary improvements.

Data cascades as useful monitoring technique Aggregated indicator data such as the kind common in national health information systems can pose challenges to facility- and district-level monitoring of quality performance. Pairing of these indicators to reflect holistic service delivery packages is helpful in setting up data personnel to visualize performance in relation to the services most dependent on each other for quality patient health outcomes. Data cascades help to group these pairs, and offer supervisors a low-effort means of helping facilities and districts to run their own analysis of gaps in service.

Competition and supportive supervision should be coupled Institutionalized systems for feedback were critical to the sustainability of data use across levels of the health system. Quarterly reviews joining multiple key stakeholders fueled competition and aided in facilities' collective desire for improvement. However, promotion of a competitive performance environment should not be pursued without equal efforts to bolster supportive supervision at the facility and district levels. All key stakeholders, from providers through to facility managers, must feel supported to make the changes necessary for quality improvement.

V. FINANCIAL REPORT

Name of Partner:	**Pathfinder International**
Name of Project:	**APHIA*plus* Northern Arid Lands**
Agreement Number:	**623-A-00-07-00023-00**
Total Estimated Cost:	$**25,753,517**
Obligated Funds:	**$25,753,517**
Future Mortgage:	**$0**
Project Start Date:	**14 May 2007**
Project End Date:	**13 May 2012**

FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted	2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment)	Page	of
RRB, Room 7.07-133 M/FM/CMP/LOC Unit 1300 Pennsylvania Ave., N.W. Washington, DC 20523-7700	623-A-00-07-00023-00	1	1 Pages

3. Recipient Organization (Name and complete address including Zip code)
Pathfinder International
9 Galen Street
Watertown, MA 02472

4a. DUNS Number	4b. EIN	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type	7. Basis of Accounting
06-215-7045	53-0235320	A00012	☐ Quarterly ☐ Semi-Annual ☐ Annual X Final (see note)	☐ Cash X Accrual

8. Project/Grant Period From: (Month, Day, Year)	To: (Month, Day, Year)	9. Reporting Period End Date (Month, Day, Year)
14-May-07	13-May-12	13-Aug-12

10. Transactions	Cumulative
(Use lines a-c for single or multiple grant reporting)	
Federal Cash (To report multiple grants, also use FFR Attachment):	
a. Cash Receipts	$25,753,517
b. Cash Disbursements	$25,753,517
c. Cash on Hand (line a minus b)	$0
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	$25,753,517
e. Federal share of expenditures	$25,753,517
f. Federal share of unliquidated obligations	
g. Total Federal share (sum of lines e and f)	$25,753,517
h. Unobligated balance of Federal funds (line d minus g)	$0
Recipient Share:	
i. Total recipient share required	$1,800,000
j. Recipient share of expenditures	$1,800,000
k. Remaining recipient share to be provided (line i minus j)	$0
Program Income:	
l. Total Federal program income earned	$0
m. Program income expended in accordance with the deduction alternative	$0
n. Program income expended in accordance with the addition alternative	$0
o. Unexpended program income (line l minus line m or line n)	$0

11. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	e. Amount Charged	f. Federal Share
				g. Totals:		

12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:
- Pathfinder International will submit a revised final financial report upon finalizing our indirect cost rate (NICRA) for the fiscal year ending June 2012.
- Final drawdown from the letter of credit account (51A5P) in the Payment Management System was done on August 14, 2012.

13. Certification: By signing this report, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalities. (U.S. Code, Title 218, Section 1001)

a. Typed or Printed Name and Title of Authorized Certifying Official	c. Telephone (Area code, number and extension)
Susan Farrell, Director of Budgeting and Financial Reporting for Thomas Downing, Chief Financial Officer	617-924-7200
	d. Email address tdowning@pathfind.org
b. Signature of Authorized Certifying Official Susan Farrell	e. Date Report Submitted (Month, Day, Year) 8/15/2012
Standard Form 425 OMB Approval Number: 0348-0061 Expiration Date: 10/31/2011	14. Agency use only:

ANNEXES

ANNEX I

PERFORMANCE MONITORING PLAN – APHIA II NEP

	Year 1	Year 2	Year 3	Oct - Dec 2010	Totals	Targets
Prevention (Abstinence and being faithful)						
Number of individuals reached through community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful	93,175	233,821	296,714	29,255	**652,965**	700,000
Number of individuals reached through community outreach HIV/AIDS prevention programs that promotes abstinence	68,012	171,762	154,153	32,001	**425,928**	160,000
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	89	785	444		**1,318**	3,789
Condoms and other prevention activities						
Number of targeted condom service outlets	31	26	37	37	**37**	30
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	3,906	109710	49,706	5,607	**168,929**	31,000
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	50	114	50	99	**313**	350
Palliative care (TB/HIV)						

Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) according to national or international standards	37	66	66	66	**66**	70
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	21	260	318	22	**621**	960
Number of TB patients who received HIV counseling, testing, and their test results at a USG supported TB outlet	0	1356	1142	354	**1,496**	2,590
Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed)	59	75	662	0	**662**	1,200
Orphans and vulnerable children						
Number of OVC served by an OVC program	3,615	6,790	11,407	11,507	**11,507**	14,950
Male	2,906	4,445	7,095	7,157	**7,157**	7,475
Female	709	2,345	4,312	4,350	**4,350**	7,475
Number of individuals trained in caring for OVC	409	334	251	147	**1,141**	500
Counseling and Testing						
Number of service outlets providing counseling and testing according to national or international standards	22	61	90	165	**165**	40
Number of individuals who received counseling and testing for HIV and received their test results	1,323	59730	120,310	184,475	**365,838**	85,000

Number of individuals trained in counseling and testing according to national and international standards	55	25	62	0	**142**	260
Strategic Information						
Number of local organizations provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS)	22	25	29	12	**88**	85
Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	39	28	74	15	**156**	180
Systems Strengthening						
Number of local organizations provided with technical assistance for HIV-related policy development	0	26	37	0	**37**	4
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	0	15	42	0	**42**	4
Number of individuals trained in HIV-related policy development	0	27	82	0	**82**	140
Number of individuals trained in HIV-related institutional capacity building	0	68	38	48	**38**	140
Palliative care (excluding TB/HIV)						
Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	23	28	35	35	**35**	90
Number of service outlets providing pediatric HIV-related palliative care (excluding TB/HIV)	4	7	20	20	**20**	4
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	0	130	116	37	**283**	190

Number of individuals provided with pediatric HIV-related palliative care (excluding TB/HIV)	0	52	161	178	**391**	440
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	1,214	1,173	2,315	2,478	**7,180**	9,530
HIV/AIDS treatment/ARV services						
Number of service outlets providing ART services according to national or international standards	4	8	20	38	**38**	20
Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)	51	267	232	154	**704**	2,600
(0-14)		17	22	18	**57**	160
(15+)		250	210	136	**596**	1,240
Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)*	412	682	918	1,483	**1,483**	1,100
(0-14)		42	62	103	**103**	100
(15+)		644	856	1,380	**1,380**	1,000
Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites), by gender, age and pregnancy status*	400	544	810	1,799	**1,799**	990
Male (0-14)	1	12	26	135	**135**	
Male (15+)	138	208	277			
Female (0-14)	1	16	27			
Female (15+)	260	270	465	1,644	**1,644**	

Pregnant female (all ages)	0	38	15	20	**20**	
Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)	49	27	68	0	**144**	150
Prevention of Mother-to-Child Transmission						
Number of service outlets providing the minimum package of PMTCT services according to national or international standards	22	96	148	148	**148**	130
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	14,050	28,863	34,565	11,074	**88,552**	105,000
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	43	56	120	31	**250**	520
Number of health workers trained in the provision of PMTCT services according to national and international standards	50	107	105	0	**262**	370
Additional Indicators						
Couple years of protection (CYP) in USG-supported programs	1,292	3,212	4,694	1,536	**10,734**	7,500
Number of people trained in FP/RH with USG funds	0	145	37	27	**209**	150
Number of counseling visits for FP/RH as a result of USG assistance	0	0	0	0	**0**	7,000
Number of USG-assisted service delivery points providing FP counseling or services	0	72	148	148	**368**	120

Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the SDP	0	0	0	0	**0**	55
Number of new FP acceptors as a result of USG assistance, by FP method	14,208	7,468	16,064	4,308	**42,048**	21,000
Pills	2,565	620	4,976	1,272	**9,433**	0
Injections	4,891	1,363	9,672	2,408	**18,334**	0
I.U.C.D.	53	5	19	*14*	**91**	0
Implants	288	75	274	63	**700**	0
Male Sterilization	0	0	0	0	**0**	0
Female Sterilization	22	0	0	0	**22**	0
Condoms	6,341	1,159	11,797	3,422	**22,719**	0
Other	48	384	1,168	551	**2,151**	0
Number of service outlets renovated or equipped to facilitate provision of HIV/AIDS or TB related services	4	0	8	14	**26**	20
Number of PLWHA support groups formed and/or linked to other services as appropriate	16	12	16	7	**51**	10
Number of health workers trained in stigma reduction	0	0	0	0	**0**	0
Number of individuals trained in the provision of laboratory-related activities	15	27	30	0	**72**	30
HQ Added Indicator for Global Database						
Total number of service delivery sites supported/established by the project	22	96	148	148	**148**	0

ANNEX II

PERFORMANCE MONITORING PLAN – APHIA*plus* NAL

Performance Indicator	Jan-Dec 2011	Jan-Apr 2012	Total NAL	NAL Target	% Target Achieved
GENDER					
# of people reached by an individual, small group or community level intervention that explicitly address norms about masculity	15,624	10,486	26,110	TBD	
Number of people reached by an individual ,small group, or community-level intervention or service that explicitly address Gender-based violence and coercion related to HIV/AIDS	18,387	5,772	24,159	TBD	
# of people reached by an individual, small group or community level intervention or service that that explicitly address the legal rights and protection of women and girls impacted by HIV/AIDS	15,746	2,468	18,214	TBD	
# of people reached by an individual, small group or community level intervention or service that that explicitly address aim to increase access to income and productive resources of women and girls impacted by HIV/AIDS	6,535	7,549	14,084	TBD	
MARP					
# of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	19,104	8,801	27,905	TBD	
PREVENTION WITH POSITIVE (PwP)					
# of (PLHIV) reached with a minimum package of prevention with PLHIV (PwP) intervention	5,751	12,835	18,586	TBD	
SEXUAL AND OTHER BEHAVIORAL RISK PREVENTION					
# of targeted population reached with individual and/or small group level prevention interventions that are based on evidence and/or meet the minimum standards required (OB/C-BAB/C)	31,211	20,402	51,613	TBD	
# of targeted population reached with individual and/or small group level prevention interventions that are primarily focused on abstinence and/or being faithful and are based on based on evidence and/or meet the minimum standards required (AB/F)	22,296	4,962	27,258	TBD	
IR3: Increased use of quality health service, products and information					

COUNSELING AND TESTING					
# of service outlet providing counseling and testing according to national or international standards	512	407	407	162	251%
# of individuals who received testing and counseling services for HIV and received their test results	252,664	41,574	294,238	281,750	118%
HIV/AIDS TREATMENT/ARV SERVICES					
# of clients with advanced HIV infection newly enrolled on ART	1,162	327	1,489	3,200	54%
Paed	136	50	186	450	74%
Adults	1,026	277	1,303	2,750	52%
# of clients with advanced HIV infection receiving ART (currently)	4,694	5,021	5,021	6,800	79%
Paed	522	572	572	1,000	57%
Adults	4,172	4,449	4,449	5,800	83%
# of clients with advanced HIV infection who ever started on ART	6,512	6,839	6,839	8,250	87%
Paed	738	788	788	1,250	63%
Adults	5,774	6,051	6,051	6,600	92%
% of adults and children known to be alive and on treatment 12 months after initiation of ART	74	78	78	83	
% of HIV positive persons receiving CD4 screening at least once during the reporting period	42	45	45	70	75%
# of HIV positive persons receiving CTX prophylaxis	12,697	13,248	13,248	13,875	110%
# of HIV clinically malnourished clients who received therapeutic or supplementary food	1,263	451	1,714		
# of service outlets providing ART services according to national or international standards	81	81	81	95	85%
PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)					
# of services outlets providing the minimum package of pmtct services according to national or international standards	357	357	357	450	79%
# of pregnant women who received HIV counseling and testing for PMTCT and received their test results	69,113	19,359	88,472	112,250	93%
Number of HIV+ mothers issued with ARV prophylaxis				1,063	67%

	414	218	632		
% of HIV positive pregnant women who received ART to reduce the risk of MTCT	93	92	92	83	
# of HIV positive pregnant women newly enrolled into HIV care and support services	630	281	911	850	107%
# of infants tested for HIV at 6 weeks	168	27	195	850	29%
% of infants born to HIV+ women who received and an HIV test within 18 months of birth	46	47	47		
# of HIV exposed infants provided with ARVs prophylaxis	430	110	540	1,063	64%
PALLIATIVE CARE (EXCLUDING TB/HIV)					
# of individuals provided with HIV related palliative care (excluding TB/HIV)	749	2,693	3,442	3,500	123%
# of individuals provided with HIV related paedratic palliative care (excluding TB/HIV)	75	438	513	1,150	51%
% of HIV positive patients who were screened for TB in HIV care or treatment settings	100	100	100		
# of HIV positive patients in HIV care or treatment (pre-art or ART) who started TB treatment	431	334	765	650	147%
# of TB patients who received HIV counseling, testing and their test results at USG supported TB outlets	3,982	1,027	5,009	4,375	143%
VMMC					
# of VMMC clients	-	290	290	4,000	7%
MNCH/RH/FP/SI					
# of deliveries performed in a USG supported health facility	24,475	6,624	31,099	30,175	124%
# of ANC visits with skilled providers in USG supported health facilities	151,917	44,872	196,789	145,000	164%
# of children less than 12 months of age who received DPT3 from USG supported programs	68,860	20,890	89,750	104,000	103%
# of children <5 years of age who received vitamin A from USG supported	322,230	50,251	372,481	224,000	185%
# of children receiving measles vaccine	80,426	24,856	105,282	73,000	
# of children receiving BCG	84,248	22,884	107,132	100,500	

# of cases of child diarrhea treated in USG supported site	149,817	29,727	179,544		
# of new FP acceptors as a result of USG assistance by FP method	93,342	18,765	112,107	37,500	359%
Pills	12,106	3,654	15,760		
Injections	43,642	12,222	55,864		
I.U.C.D.	396	187	583		
Implants	1,093	520	1,613		
Male Sterilization	1	21	22		
Female Sterilization	21	4	25		
Condoms	32,522	13,645	46,167		
Other	3,561	492	4,053		
3.1 increased availability of an integrated package of quality high impact intervention at community and facility levels					
# of services availability of an integrated package vitamin A from usg supported program	275	275	275		
# of service outlets providing HIV related palliative care (excluding TB/HIV)	209	209	209	195	107%
# of service outlets providing hiv related paedratic palliative care (including TB/HIV)	88	88	88	130	68%
# of service outlets providing PEP	84	330	330	120	275%
% of pregnant women receiving 2 doses of IPT	92	94	94		
# of service outlets providing clinical prophylaxis and/or treatment for TB to HIV related individual (diagnosed or presumed according to national or international standards	87	87	87	170	51%
# of USG assisted service delivery points providing FP counseling or services	395	395	395	450	88%
CYP provided through USG supported programs	20,977	6,918	27,895	18,500	186%
# of targeted condoms service outlets	200	200	200	210	105%

# of condom distributed (GOK health seek indicator and standard OP)	379,528	98,753	478,281	300,000	199%
% of district with community IMCI intervention	87	88	88		
# SP participating in CME or CE	5,977	1,122	7,099	1,000	710%
# of service outlets integrating HIV/AIDS, TB, RH/FP, malaria and MNCH services by facility type	230	230	230	170	135%
% of facilities with stock outs of methods	-	-	-		
# of service outlets with full contraceptive method mix	219	219	219	88	249%
# of mobile units with providing testing	70	70	70	46	152%
# of service outlet with youth friendly services	81	81	81	28	289%
3.2 Increased demand for a integrated package of quality high impact intervention at community and facility					
# of facilities with private counseling areas	237	237	237	49	484%
# of facilities with functioning facility management committee	188	188	188	75	251%
# of functioning Community Units (GOK Heath sector indicators and SOP manual)	27	27	27		
# communities implementing the CS	25	33	33		
3.3. Increased adoption of healthy behavior					
# of BCC products distributed by type	8	8	8	15	53%
3.4 Increased program effectiveness through innovative approaches					
% of facilities use data for performance monitoring	100	100	100		
# of CU using data for DM	25	25	25	15	167%
# of eligible adults and children provided with a minimum of one care service	35,939	37,894	37,894	38,750	122%
# of local organization and service points provided with technical assistance for strategic information	28	13	28	135	21%
# of local organizations and service points provided with technical assistance for HIV related policy development	31	14	31		

# of local organizations and service points provided with technical assistance for HIV related institutional capacity building	27	11	27		
IR4: Social determinant of health addressed to improve the wellbeing of the community, especially marginalized poor and underserved population					
4.1. Marginalized poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs					
# of people actively involved in economic security initiatives through project linkages	2,212	1,284	3,496	1,000	350%
# of PLHIV support groups formed and/or linked to other service as appropriate	32	23	32	16	200%
4.2: Improved food security and nutrition for marginalized poor and underserved population					
# of eligible clients who received food and/or other nutrition services	22,163	5,681	27,844	12,500	278%
4.3: Marginalized poor and underserved groups have increased access to education, life skills and literacy initiatives through coordination and integration with education program					
# of schools supported by child friendly program	87	50	87	87	100%
# of youth trained in life skills	8,532	2,288	10,820	19,375	70%
# of OVC enrolled in ECD program through APHIAplus referrals	2,521	416	2,937	4,000	92%
4.4: Increased access to safe water, sanitation and improved hygiene					
# of water and/or sanitation projects established in project supported facilities through linkages with usg funded WSS project	54	3	57	80	71%
# of organization and outlets selling POU and SW project through linkages with HCM project	21	1	22	90	24%
# of hygiene sessions held at schools	5,350	113	5,463	420	1301%
4.5 Strengthening systems, structures and services for protection of marginalized poor and underserved population					
# of OVC assisted by the project to obtain legal birth certificate	2,408	1743	4,151	8,750	59%
# of VHH identified and referred to services	2,181	2445	4,626	1,813	319%
4.6 Expanded social mobilization for health					
# of RL who are advocating for reduced stigma and improved MNCH	246	230	230	11	2091%

ANNEX III

List of Publications and Quarterly Reports

Title	Date
Strategies to Improve Access to Health Services in Garissa County	No date listed
Twaweza - Strategic Behavior Communication for APHIA II North Eastern	No date listed
Report of Human Resources for Health (HRH) Rapid Assessment in North Eastern Province (NEP) Kenya	January, 2008
The Muslim Scholars of North Eastern Province on Islam and Health: Challenges and Opportunities	April 22, 2008
The Sexual Networks Study: Secondary Bachelors and Sexual Pensions	September, 2009
ALPHIA II North Eastern Province Newsletter Edition III	September, 2009
What Islam Says about Stigma and Discrimination (video)	December 22, 2010
APHIAplus Update Volume 1, Issue 1	February, 2011
APHIAplus Update Volume 1, Issue 2	March, 2011
APHIAplus Update Volume 1, Issue 3	May, 2011
APHIAplus Update Volume 1, Issue 4	June, 2011
PROJECT START UP: STORIES FROM TURKANA COUNTY	June, 2011
APHIAplus Update Volume 1, Issue 5	June-July, 2011
Evidence for interventions to reduce HIV/STI risk in Isiolo Town and Surrounding Communities	July, 2011
APHIAplus Update Volume 1, Issue 6	August, 2011
APHIAplus Update Volume 1, Issue 7	September, 2011
Evidence for interventions to reduce HIV/STI risk in Lodwar, and Surrounding Communities in Turkana County	September, 2011
APHIAplus Update Volume 1, Issue 8	October-November, 2011
Quarterly Reports (Chronological Order)	
Title	**Date**
Quarterly Report	May 1 - June 30, 2007
Quarterly Report	July 1 - September 30, 2007
Quarterly Report	October 1 - December 31, 2007
Quarterly Report	January 1 - March 31, 2008
Quarterly Report	April 1 - June 30, 2008
Quarterly Report	July 1 - September 30, 2008
Quarterly Report	October 1 - December 31, 2008
Quarterly Report	January 1 - March 31, 2009
Quarterly Report	April 1 - June 30, 2009
Quarterly Report	July 1 - September 30, 2009
Quarterly Report	October 1 - December 31, 2009
Quarterly Report	January 1 - March 31, 2010
Quarterly Report	April 1 - June 30, 2010

Quarterly Report	July 1 - September 30, 2010
Quarterly Report	October 1 - December 31, 2010
Quarterly Report	January 1 - March 31, 2011
Quarterly Report	April 1 - June 30 2011
Quarterly Report	July 1 - September 30 2011
Quarterly Report	October 1 - December 31, 2011
Quarterly Report	January 1-March 31, 2012

ANNEX IV

RESOLUTIONS OF THE MUSLIM SCHOLARS OF NEP CONFERENCE ON ISLAM AND HEALTH

1. The Scholars advised the community to ease the marriage process by lowering the amounts demanded for dowry and wedding ceremonies as high cost of marriages has led to high rates of immorality and adultery. They also advised the grooms to pay all or part of the dowry at the engagement time.

2. The Scholars advised the Muslim community to get the marriage and divorce certificates from authorized registered Muslim marriage registrars to cap the abuse of marriage and divorce contracts.

3. The high rate of divorce in NEP has become a major concern and has many causes, among them being failure to adhere to the Islamic teachings in the married life such as husbands' failure to exercise their responsibilities towards their families while others are caused by wives who constantly demand for divorce for petty grievances which can easily be resolved. Women's open disobedience to husbands and social norms are also considered as contributing factors.
    - The Muslim scholars stressed their discouragement of divorce solutions rather than married couples seeking reconciliation.
    - High divorce rates lead to spread of HIV/AIDS as well as child delinquency and the unnecessary suffering of divorcees.

4. It is not permitted in Islam to discriminate or look down upon anyone whether sick or healthy, Allah said, "Oo people, no men folk should look down upon other men folk for they could be more righteous than them, and no women should look down upon other women for they could be more righteous than them."

5. The Scholars have advised that couples should undergo HIV test before marriage as a protection method against the contraction of the disease.

6. Wife inheritance is prohibited in Islam, and a widow has the right to marry whomever she likes from the relatives of her deceased husband or any other men. Therefore the relatives of her late husband have no right to render her unmarriable or exchange her marriage to an outsider with any form of payment. Therefore the bad customs, which are prevalent in NEP community, is against the Islamic Sharia. Allah said, "Oh, you who believe, you have no right to inherit the women or stop them from marrying (the men of their choices."

7. They Muslim Scholars discussed the people living with HIV/AIDS whether their confidentiality should be maintained or revealed, and the Scholars agreed that the Islamic Sharia has commands that a Muslim's confidentiality should be kept and to reveal him is a contravention. However, due to the danger of HIV/AIDS pandemic they agreed that his closest relatives should be informed about his infection as a precaution.

8. The Scholars advised that the distribution of condoms among the Muslim community is not acceptable as it is encouraging the spread of adultery. The Scholars thus urge Muslims to fear Allah and practice faithfulness among the married couples and abstinence among the singles for protection against HIV/AIDS.

9. The Scholars advised that if an HIV/AIDS patient spreads the disease among the innocent deliberately, he is considered to be a killer in the eyes of the Sharia and the relevant officers should take legal action against him.

10. The Scholars advised Imams to announce the dangers of HIV/AIDS during the Friday sermons.

11. The meeting scholars warned the Muslim community that Miraa is considered as one of the most dangerous ***haram*** (unlawful) drugs in the Islamic Sharia. They cautioned that Miraa leads to family break-ups, promotes immorality, poor health and devastates the economy of the community. Therefore, the scholars advised the Muslim community to stop the trade and consumption of Miraa. They also urged the government and MPs to take serious and honest steps to ban it urgently.

12. The Scholars resolved that expectant mothers should attend MCH clinics and encouraged them to deliver in hospitals for their safety and that of their babies.

13. The Scholars urged health services providers to deploy female midwives as male attendants are only allowed in cases of emergency.

14. As regards the consent to perform Caesarian section operation on women at the hospitals, the Scholars advised that giving the consent is the prerogative of the patient unless she is unconscious in which case her husband or next of kin can give consent. They further advised that medical doctors could always intervene to save lives at critical times.

15. The Scholars advised mothers to breast-feed their babies for their healthy growth as recommended by the Quran.

The verse from Al-Ahqaf is interpreted as follows:

We have enjoined man to show kindness to his parents. With much pain his mother bears him, and with much pain she brings him into the world. He is born and weaned in thirty months.

The verse from El-Baqharah tells us:

Mothers shall suckle their children for two whole years; (that is) for those who wish to complete the suckling. The duty of feeding and clothing nursing mothers in a seemly manner is upon the father of the child.

The English of the Luqman verse is:

We enjoined man to show kindness to his parents, for with much pain his mother bears him and he is not weaned before he is two years of age.

16. The Scholars resolved that planning pregnancies and spacing of births for the promotion of mothers and babies health allow the use of all permissible and safe methods of contraceptives.

17. Women have the right to all useful education whether formerly or through health seminars if the Sharia conditions are observed such as avoidance of free mixing of the opposite sexes and traveling of a woman without the a company of a closely related male escort.

18. Circumcision is mashruu' (has basis) in Islam for both males and females. However, *alkhitan alfir'auni* (FGM) is unlawful *(haram).* As it is a major cause of the sufferings of women at birth leading to other health complications and mortalities.

19. The Scholars announced that eloping with girls for marriage without the permission of their parents/guardians contravenes the dictates of the Sharia. Therefore, no marriage can take place in such circumstance, hence the Scholars warn against this custom.

20. Marrying off a pregnant woman (until she gives birth) is haram in the Sharia and no marriage can be consummated in such circumstances, and whoever does so, is a sinner and a transgressor of Allah's commandments. Allah said, "And for those who are pregnant (whether they are divorced or their husbands are dead), their ***'iddah*** (prescribed period) is until they give birth….". The Scholars advised the Kadhis in the region to take legal action against those who consummate such marriages.

21. High level workshop be held for the Islamic leaders to be trained on basic facts on HIV/AIDS, TB and malaria as well as reproductive health issues as soon as possible.

ANNEX V

MOU Between APHIA*plus* NAL and NHP

Drought Response in the Northern Arid Lands: Scaling-up nutrition services

Context

APHIA*plus* NAL is planning to support delivery of a package of services to mitigate the effects of drought and famine among communities living in the in northern arid and semi-arid region of Kenya. Central to this package are health workers, nutritional commodities and water. To expedite this response and enhance leveraging of resources, APHIA*plus* NAL will collaborate with NHP, Ministry of Health officials and other stakeholders to scale up nutrition assessment, counseling and food by prescription services in early detection and management of clinical malnutrition among patients visiting facilities and in the community. The purpose of this collaboration is accelerate the delivery of nutrition services to the most vulnerable with a view to close gaps that ongoing food aid programs may not effectively cover.

NHP is currently supporting delivery of NACS and FBP in five out of the eight counties that are supported APHIA*plus* NAL. In this regard, NHP is supporting two primary sites in both Turkana and Tana River counties, one site in the counties of Isiolo, Samburu and Garissa. The scale-up of services to Marsabit was scheduled take place later in the year. Garissa county site has scaled up services to Wajir and Mandera as satellite sites. Only Garissa and Kakuma sites have scaled up sites to satellite sites.

Strategy

To improve access to NACS services across the eight counties that are supported APHIA*plus* NAL, the collaborating partners will scale-up services and commodities to all primary and satellite sites in the counties. It is expected that the NACS sites will in turn work with local CBOs and carry out community outreach activities to further increase accessibility of these services to the communities.

Implementation

The following steps are envisaged:

1. Consultative meetings in two sub-regions (Northern Rift Valley and Upper Eastern) with PHMTs and DHMTs (Action: APHIA*plus* NAL and NHP)
2. Concurrence on primary and satellite site selection. (Action: APHIA*plus* NAL and NHP)
3. Training of health care providers in North Rift and Upper Eastern sub-regions. Garissa, Wajir and Mandera in NEP had refresher training in NACS/FBP in May 2011. Tana River county sites were trained November 2010. (Action: APHIA*plus* NAL and NHP)*
4. Delivery of supplemental and therapeutic food commodities and WaterGuard to the trained sites and initiate monitoring of the distribution (Action: NHP).
5. Delivery of supplemental and therapeutic food commodities and WaterGuard to the trained satellite sites and support monitoring (Action: APHIA*plus* NAL).
6. Training of CHWs and CHEWS in NACS (Action: NHP and APHIA*plus* NAL supported CBOs)

7. Delivery of supplemental food commodities and WaterGuard to trained CBOs sites and support monitoring (Action: APHIA*plus* NAL).
8. Training of health workers from primary sites in the regular 5 day national training in Nutrition and HIV. The trainees will serve as coaches and mentors in quality improvement interventions in respective sites and the satellite sites already supported by APHIA*plus* NAL. (Action: NASCOP/NHP)******.
9. Data analysis (Process and impact). (Action: NHP and APHIA*plus* NAL)

*** -** It is expected that a 2-3 day induction training including practicums on NACS will be carried out at ground level. APHIA Plus support this phase of training and NHP will provide technical assistance.

 # - In NEP, and Tana River County it is envisaged that the proposed set of activities would target additional satellite sites and community level interventions

**** -** NHP will support the national level training of two staff from every primary site

Coordination and administration

1. APHIA*Plus* NAL to convene consultative meetings that will be held concurrently at the Northern Rift Valley and Upper Eastern sub-regions. The second wave will cover counties in NEP and Tana River counties. NHP requests APHIA*Plus* NAL to include nutrition services agenda when sensitizing the PDMs/PDPHS.
2. APHIA*Plus* NAL to facilitate invitation of representatives from the Provincial Health Management Team (PHMT) - the Provincial nutritionists.
3. NHP to sensitize National Office and ensure concurrence for follow-up actions especially the national trainings.

Projections of the needs will be provided through a consultative process by the nutrition focal persons in the sites, sub-regional APHIA*Plus* NAL officials and NHP.

ANNEX VI

Renovations Implemented during APHIA II NEP

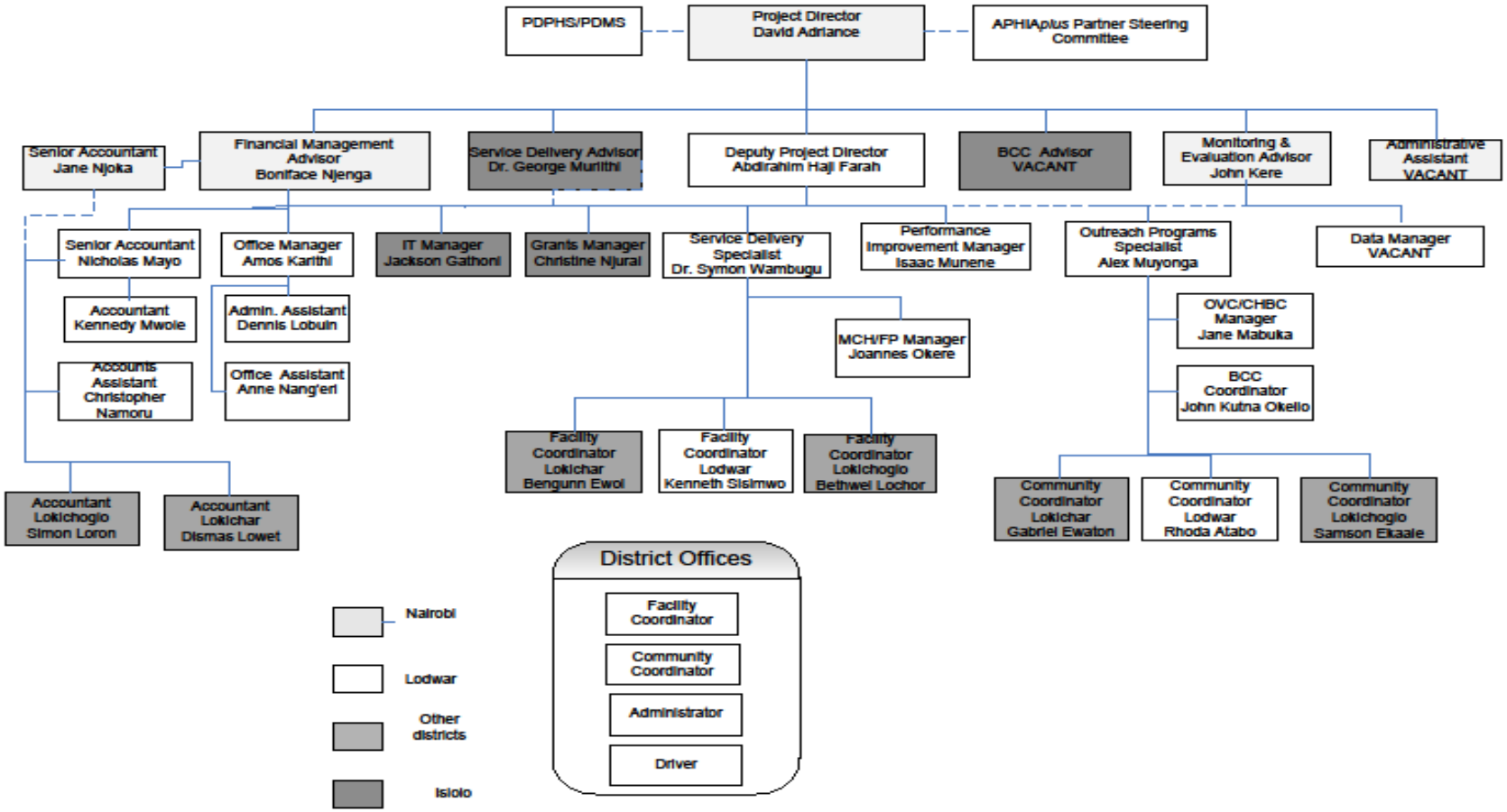
District	Facility	Department
Wajir East	Wajir DH	CCC Partitioning
		Laboratory
	Khorofharar SDH	Laboratory
		VCT
	Tarbaj	Laboratory
Wajir West	Griftu DH	Laboratory
		VCT
Wajir North	Buna SDH	OPD block
		VCT
	Bute	VCT
Mandera West	Dandu	Laboratory
	Guba	Laboratory
	Takaba D.H.	VCT
Mandera East	Mandera DH	Maternity
		CCC
		CCC Extra works
Mandera Central	Elwak DH	Laboratory
		VCT
		Records office
	Asabito	Maternity
		Laboratory
	Rhamu	VCT
Wajir South	Diff	Laboratory
	Darjabulla	
	Habaswein D.H	VCT
Dujis	Iftin SDH	Lab & waiting bay
	Iftin SDH	Extra works
	G.K. Prisons	Laboratory
Ijara	Kotile	Facility
	Masalani D.H.	Lab & TB Rooms
	Ijara H.C.	Lab

	Ijara H.C.	VCT
Fafi	Nanighi	Facility
	Fafi Dispensary	Facility/Lab
Garissa	PGH	TB Clinic
		TB Clinic extras
		Nutrition room
	PGH	CCC Renovations
Lagdera	Modogashe DH	Laboratory
	Banane Dispensary	Laboratory
	Dertu Dispensary	Maternity

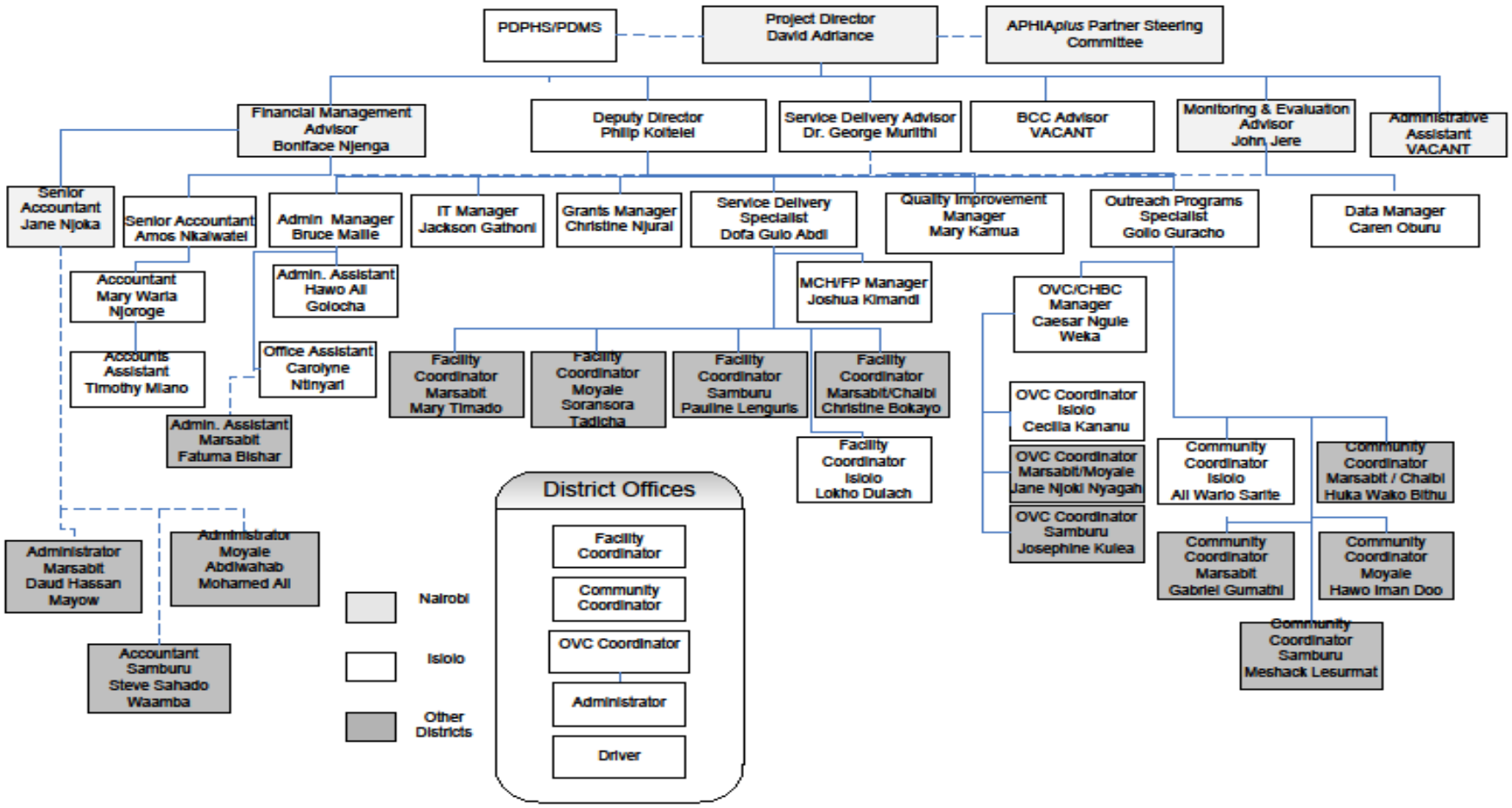
ANNEX VII

Implementing Partners Organograms By Sub-Region

APHIA*plus* Northern Arid Lands
Organizational Chart
Turkana



APHIA*plus* NAL Organizational Chart
Upper Eastern plus Samburu



APHIA*plus* NAL Organizational Chart,
North Eastern Province & Tana River